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School of Health and Social Welfare

**Transport planning for health: Explaining and evaluating
barriers and opportunities to intersectoral collaboration**

A thesis submitted to the Open University
in candidacy for the degree of Doctor of Philosophy

by

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July 2001

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Abstract

The establishment in the 1980s of a European Health for All strategy and set of targets has implications for transport planning policy across Europe. Potentially, Health for All provides a means by which transport planning can better promote public health. Key to this is the ability of local Health for All projects to develop effective intersectoral collaboration with transport planning professionals. The progress of Health for All in influencing priorities in transport planning is explored through a comparative study of Health for All collaborating cities in Denmark, the Netherlands and England between 1986 and 1996. Three cities are used as case studies: Copenhagen, Groningen, and Sheffield.

The study examines the extent to which transport policies have been influenced by Health for All strategies and targets. Archival and interview data are used to explore the nature and degree of intersectoral collaboration between Health for All projects and transport planning departments. The research contributes to knowledge about how Health for All can influence transport planning in promoting health, an issue largely neglected in the literature.

There are similarities and differences between Health for All projects studied in the way that they have sought to develop intersectoral collaboration on transport issues. The research highlights common barriers to effective collaboration, but also how Health for All projects could develop collaborative initiatives. It indicates that health needs to be translated into values such as quality of life, equity, and environmental protection, found to be policy drivers within transport planning. Quality of life and equity are identified in Health for All targets but were not drawn on sufficiently by health promoters. The study findings also underscore the importance of national policy frameworks on both health and transport which can provide common ground between the two sectors. The most successful city Health for All project was characterised by concerns for environmental protection and quality of life, with supportive national government frameworks for health promotion and transport planning.

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Targets for Health for All (1991 edition)

Target 1 Equity in health

By the year 2000, the difference in health status between countries and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups

Target 2 Health and quality of life

By the year 2000, all people should have the opportunity to develop and use their own health potential in order to lead socially, economically and mentally fulfilling lives.

Target 3 Better opportunities for people with disabilities

By the year 2000, people with disabilities should be able to lead socially, economically and mentally fulfilling lives with the support of special arrangements that improve their relative physical, social and economic opportunities.

Target 4 Reducing chronic disease

By the year 2000 there should be a sustained a continuing reduction in mortality and disability due to chronic disease in the Region.

Target 5 Reducing communicable disease

By the year 2000 there should be no indigenous cases of poliomyelitis, diptheria, neonatal tetanus, measles, mumps and congenital rubella in the Region and there should be a sustained and continuing reduction in the incidence and adverse consequences of other communicable disease, notably HIV infection.

Target 6 Healthy aging

By the year 2000, life expectancy at birth in the Region should be at least 75 years & there should be a sustained & continuing improvement in the health of all people aged 65 years & over.

Target 7 Health of children and young people

By the year 2000, the health of all children and young people should be improved, giving them the opportunity to grow and develop to their full physical, mental and social potential.

Target 8 *Health of women*

By the year 2000, there should be sustained and continuing improvement in the health of all women.

Target 9 *Reducing cardiovascular disease*

By the year 2000, mortality from diseases of the circulatory system should be reduced, in the case of people under 65 years by at least 15%, and there should be progress in improving the quality of life of all people suffering from cardiovascular disease.

Target 10 *Controlling cancer*

By the year 2000, mortality from cancer in people under 65 should be reduced by at least 15% and the quality of life of all people with cancer should be significantly improved.

Target 11 *Accidents*

By the year 2000, injury, disability and death arising from accidents should be reduced by at least 25%.

Target 12 *Reducing mental disorders and suicides*

By the year 2000, there should be a sustained and continuing reduction in the prevalence of mental disorders, an improvement in the quality of life of all people with such disorders, and a reversal of the rising trends in suicide and attempted suicide.

Target 13 *Healthy public policy*

By the year 2000, all Member States should have developed, or be implementing, intersectoral policies for the promotion of healthy lifestyles, with systems ensuring public participation in policy making and implementation.

Target 14 *Settings for health promotion*

By the year 2000, all settings of social life and activity, such as the city, school, workplace, neighbourhood and home, should provide greater opportunities for promoting health

Target 15 Health competence

By the year 2000, accessible and effective education and training in health promotion should be available in all Member States, in order to improve public and professional competence in promoting health and increasing health awareness in other sectors.

Target 16 Healthy living

By the year 2000, there should be continuous efforts in all Member States to actively promote and support healthy patterns of living through balanced nutrition, appropriate physical activity, healthy sexuality, good stress management and other aspects of positive health behaviour.

Target 17 Tobacco, alcohol and psychoactive drugs

By the year 2000, the health-damaging consumption of dependence-producing substances such as alcohol, tobacco and psychoactive drugs should have been significantly reduced in all Member States.

Target 18 Policy on environment and health

By the year 2000, all Member States should have developed, and be implementing, policies on the environment and health that ensure ecologically sustainable development, effective prevention and control of environmental health risks and equitable access to healthy environments.

Target 19 Environmental health management

By the year 2000, there should be effective management systems and resources in all Member States for putting policies on environment and health into practice.

Target 20 Water quality

By the year 2000, all people should have access to adequate supplies of safe drinking-water and the pollution of ground water sources, rivers, lakes and seas should no longer pose a threat to health.

Target 21 Air quality

By the year 2000, air quality in all countries should be improved to the point at which recognised air pollutants do not pose a threat to public health.

Target 22 *Food quality and safety*

By the year 2000, health risks due to microorganisms or their toxins, to chemicals and to radioactivity in food should have been significantly reduced in all Member States.

Target 23 *Waste management and soil pollution*

By the year 2000, public health risks caused by solid and hazardous wastes and soil pollution should be effectively controlled in all Member States.

Target 24 *Human ecology and settlements*

By the year 2000, cities, towns and rural communities throughout the Region should offer physical and social environments supportive to the health of their inhabitants.

Target 25 *Health for people at work*

By the year 2000, the health of workers in all Member States should be improved by making work environments more healthy, reducing work-related diseases and injury, and promoting the wellbeing of people at work.

Target 26 *Health service policy*

By the year 2000, all Member States should have developed and be implementing, policies that ensure universal access to health services of quality, based on primary care and supported by secondary and tertiary care.

Target 27 *Health service resources and management*

By the year 2000, health service systems in all Member States should be managed cost-effectively, with resources being distributed according to need.

Target 28 *Primary health care*

By the year 2000, primary health care in all Member States should meet the basic health needs of the population by providing a wide range of health-promotive, curative, rehabilitative and supportive services and by actively supporting self-help activities of individuals, families and groups.

Target 29 *Hospital care*

By the year 2000, hospitals in all member States should be providing cost-effective secondary and tertiary care and contribute actively to improving health status and patient satisfaction.

Target 30 *Community services to meet special needs*

By the year 2000, people in all Member States needing long-term care and support should have access to appropriate services of a high quality.

Target 31 *Quality of care and appropriate technology*

By the year 2000, there should be structures and processes in all Member States to ensure continuous improvement in the quality of health care and appropriate development and use of health technologies.

Target 32 *Health research and development*

By the year 2000, health research should strengthen the acquisition and application of knowledge in support of health for all development in all Member States.

Target 33 *Health for All policy development*

By the year 2000, all Member States should have developed, and be implementing, policies in line with the concept and principles of the European health for all policy, balancing lifestyle, environment and health service concerns.

Target 34 *Managing Health for All development*

By the year 2000, management structures and processes should exist in all Member States to inspire, guide and coordinate health development, in line with health for all principles.

Target 35 *Health information support*

By the year 2000, health information systems in all Member States should actively support the formulation, implementation, monitoring and evaluation of health for all policies.

Target 36 *Developing human resources for health*

By the year 2000, education and training of health and other personnel in all Member States should actively contribute to the achievement of health for all.

Target 37 *Partners for health*

By the year 2000, in all Member States, a wide range of organizations and groups throughout the public, private and voluntary sectors should be actively contributing to the achievement of health for all.

Target 38 *Health and ethics*

By the year 2000, all Member States should have mechanisms in place to strengthen ethical considerations in decisions relating to the health of individuals, groups and populations.

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Chapter 1

Introduction

1.1 Background to the study

During the late 1980s and early 1990s I worked for an environmental pressure group and developed a keen interest in transport issues. A major stimulus to this research was the possibility it presented for studying transport policies as they went through a period of change. Transport policy makers were, in some cases, giving serious consideration to health promoting transport policies but these were the outcomes of concern for the environment rather than health. It seemed possible that this might change as the World Health Organisation (WHO) initiated Health for All projects, launched in 1986, became more established. I theorised that such external pressures might also broaden the views of transport planners about health issues. Where road transport had been considered in health policy, it had been done so from a narrowly visioned and largely quantitative perspective (Fletcher and McMichael, 1997). The dominance of quantitative approaches to policy development within both the health and transport sectors had led to a general perception that the impacts of transport on health were only those open to direct observation: traffic casualties, air and noise pollution. This was epitomised in the 1989 WHO European Charter on Environment and Health which, where it addressed road transport, focused almost exclusively on these impacts. This approach did not challenge the dominance of an increasing health damaging transport system in England, where transport policy was predicated on an unquestioned expectation that private motor transport was the norm. The effect of the growing use of private motorised transport was not considered in terms of what this might mean for public health.

It seemed possible that such a challenge might be mounted by supporters of a Health for All approach. The Charter did give some signals about the need to change, stating that:

“Intersectoral action is urgently needed throughout Europe to develop and implement healthier transport policies.” (WHO, 1990 p. 83)

Increasing concern for environmental issues was evident in some parts of Europe by the mid 1980s. In the course of my work as a transport researcher, I had visited the continental cities which I subsequently chose for this study. Safety for pedestrians and cyclists was given high priority and land use policies supported these modes by keeping distances between facilities as short as possible. Attempts were also made in both cities to restrain car traffic. With between a quarter and a half of all travel by bicycle and a relatively safe traffic environment for pedestrians, many citizens were regularly being physically active as part of their daily travel routines, while public transport provided another alternative to car use. The transport policies of cities such as Copenhagen and Groningen were, therefore, promoting health through daily travel. It was not clear, however, whether health concerns had played a role in determining transport policies in these cities. In contrast, transport policies in England appeared to be strongly oriented around accommodating increasing use of private motorised transport, with little attempt to provide for, or promote, walking and cycling.

In the early 1990s, examples of links between Health for All initiatives and transport in Europe were few, with initiatives mostly limited to reducing traffic casualties, and policies focused on risk reduction rather than health promotion. There also seemed to be little literature on intersectoral collaboration between the health and transport sectors. By contrast, I was aware that environmental concerns in continental Europe from the 1960s had led to lobby groups and individuals pressing governments to address policies which were seen to be contributing to environmental degradation. Motorised road transport was a prominent area given, for example, its effect upon travel by non-motorised modes, air quality, climate change, and land use. From the 1970s, some national governments responded with programmes to address environmental problems, and began to integrate policies across the sectors

in order to be more effective. Most European governments further developed their environmental policies in the early 1990s, stimulated by the Brundtland Report *Our Common Future* in 1987 and the Earth Summit in Rio de Janeiro in 1992.

During the period of study, 1986-1996, the level of interest in health and transport rose significantly. By 1996 there was notably more research being carried out in England, some of which was being funded by national government departments of health and transport. In 1996 the British Medical Association (BMA) contracted me to write the report 'Road Transport and Health' after its Annual Representative Conference passed a resolution that the BMA should produce a report setting out the impacts of transport on health (Davis, 1997). The former Health Education Authority (HEA), now the Health Development Agency, became increasingly interested in transport, particularly transport as physical activity, during the course of its 1996-1999 'Active for Life' campaign. A number of reports were published by the HEA on transport issues (Health Education Authority, 1998; 1999a; 1999b). In 1999 the Faculty of Public Health Medicine, (a professional organisation which administers examinations in the field of public health) set up a working group to produce its own statement on health and transport. In the same year, the WHO (Europe) commissioned research in preparation for the third Ministerial Conference on Environment and Health, held that June. This involved the production of a range of papers on disparate aspects of health and transport such as physical activity, noise, economic evaluations, accidents, and air pollution. Such publications are indicative of the increasing attention being given to the links between health and transport, attention which was absent at the commencement of my registration for study in 1994.

Most of such recent research has, however, provided only descriptive accounts of the range of health impacts arising from road transport, and how they affect groups within the population, such as children and older people. This literature has not involved any significant analysis of how health

promoting transport policies can best be developed. Central to a better understanding of this involves learning how intersectoral collaboration on health and transport has been initiated and developed between representatives of these two sectors, what difficulties can beset collaborative attempts, and why initiatives fail or succeed.

1.2 The focus of the research

The initial title of the research was 'Public policy and the impact of transport on public health'. This evolved during the first two years of study to reflect issues identified through planning and pilot study stages, becoming 'Transport planning for health: Explaining and evaluating barriers and opportunities to intersectoral collaboration'. The start date, 1986, reflects when Health for All projects were launched in Europe, and the end date, 1996, is the year in which fieldwork was completed. This means that events after 1996 such as organisational restructurings (eg in the NHS), developments in health promotion and transport planning etc... are not accounted for.

The general aim of the research has been to make an original contribution to knowledge about intersectoral collaboration on health and road transport. In particular it has sought to identify and explore barriers to, and models of, effective intersectoral action. In the absence of other primary research specifically focused on intersectoral collaboration on health and transport, I wanted to set out to gain an understanding of the issues that determined whether intersectoral collaboration on transport took place: where it did, why it did, and what the outcomes were. The establishment of Health for All projects across Europe from 1986 provided a test-bed through which I could examine whether, by the mid 1990s, Health for All projects were having an influence on local transport planning policy.

1.2.1 Aims and key questions

Specifically the aims of the research were to:

- **compare English, Dutch and Danish approaches to intersectoral collaboration on transport and health using specific case study examples and examine the role of Health for All in each case**
- **assess the influence of Health for All on transport planning policies in each case**
- **highlight from the case examples of intersectoral collaboration on transport and health where transport policies were influenced by Health for All, and the policies, practices and other methods used**
- **identify the potential for health promoting transport planning in England.**

The focus on Health for All derived from my reading of the original thirty-eight targets for Health for All (WHO, 1985). This suggested that bold and ambitious actions would be needed to meet the range of targets. Moreover, this required attention to be directed to the impacts on health across a range of sectors beyond health. A number of targets related to the impacts of transport on health.

The research questions were devised, therefore, to assess:

- **whether Health for All had any influence on transport planning in the cities under study?**
- **where Health for All did have some influence, how much and what kind of influence did it have?**
- **what were the barriers encountered by Health for All in attempts to influence transport planning?**
- **what evidence was there of intersectoral working and the limits to this?**
- **what were the most significant drivers of transport planning policy in the cities under study?**
- **what lessons can be learnt about possible ways forward for Health for All/Healthy Cities in trying to influence transport planning policy?**

1.3 Notes on terminology used

Some terms used within the thesis require some explanation. The first of these is 'local government', the term usually applied in England to government at the district level. This is used in the text as synonymous with 'municipal government', the term commonly used in countries such as Denmark and the Netherlands.

Secondly, in Europe 'transport planning' is a term generically applied to a range of disciplines which address various aspects of road transport, not just engineering and infrastructure provision (Tengstrom, 1999). The diversity of professions is reflected by the professional bodies represented within the UK Transport Planning Society. The Transport Planning Society¹ is supported not only by the Institution of Civil Engineers, Institution of Highways and Transportation and Chartered Institute of Transport, but also by the Royal Town Planning Institute (RTPI). The RTPI is concerned with economic, environmental and social issues and with transport because of its importance in how settlements operate (Bayliss et al, 1996). As such, the RTPI represents town, transport and land use planners. There are some local variations used within transport planning. In Sheffield, the transport planners used the term transportation planning to denote their broad and inclusive approach to transport, 'we're transportation and not transport. Transport is the movement of vehicles whereas transportation is much wider than that' (Silvani, 1996).

Thirdly, the disciplines within transport planning are themselves located within what constitutes the broad ranging transport sector, just as disciplines can be identified within public health, itself located within a similarly broad ranging health sector. The broad ranging transport sector includes shipping,

¹ There are no equivalent transport planning societies in either Denmark or the Netherlands. In these countries professional interests are largely articulated through university transport research departments and national transport research institutes.

aviation, rail and road transport. This study is confined to road transport and, unless specifically stated otherwise, where 'transport' is discussed in the text this refers solely to road transport.

Finally, as will be discussed in Chapter 3, it is worth highlighting the difference between Healthy Cities and Health for All. Healthy Cities have been described by the WHO as 'field laboratories' for testing Health for All initiatives. They should be seen as one particular type of Health for All project, differing principally from others because of their WHO designation as 'Healthy Cities' and the resources that are associated with the designation. Of the case study cities, Copenhagen had been designated as a Healthy City while Groningen and Sheffield were cities in which Health for All projects had been established.

1.4 The structure of the study

Chapter 2 explores debates in the literature about transport planning, principally those concerned with England. It examines how transport planning came to be largely oriented to the expansion of highway infrastructure for the benefit of motorists, and what this meant for those who did not drive. Issues of access and quality of life have been identified as important within transport planning and definitions of these are discussed. In order to provide an overview of the different approaches to transport planning in the three countries studied in the thesis the chapter includes a review of the drivers of Danish and Dutch transport planning in recent decades.

Chapter 3 explores debates in the health policy literature that highlights key debates in relation to the development of Health for All within Europe. Particular aspects, such as Healthy Cities, and intersectoral collaboration are discussed. The chapter concludes with a review of how quality of life has been defined within health and environmental accounts and which of these definitions may be most pertinent to this research.

Chapter 4 sets out the methods and methodological approach used. A key decision was to use qualitative research methods and the reasoning for this is set out. The principal aim of the research was to explore whether Health for All projects had an influence on transport planning at the city level. A case study approach was adopted in order to address in detail the research questions in cities in Denmark, the Netherlands, and England. The lessons learnt from a pilot study and its implications for the main study are addressed. The main study involved a combination of face-to-face interviews and archival data. Issues of data collection, analysis, and reflections on the research process are then explored.

In chapters 5-7 the findings from the archival and fieldwork data from the three case studies are examined. The chapters provide overviews of national policies on health and transport, including key policy initiatives during the period 1986-1996. They also provide an analysis of the influence of national health policies on the development of Health for All and of national transport planning policies on transport planning at the local level, and evidence of collaboration between the two sectors. The chapters then address policies on Health for All and transport at the level of the city in Copenhagen, Groningen, and Sheffield. Each chapter explores the views of key transport and health planners from each of the cities as to the influence of Health for All on transport policy. Barriers to intersectoral collaboration are identified. In the light of the data analysis, each chapter concludes with a discussion of the drivers of transport policy within the respective cities.

Chapter 8 provides a discussion of the findings. It addresses barriers to intersectoral work on health and transport: political; professional; organisational. Drawing on key transport policy drivers at the city level from each of the case studies, the chapter identifies the policy framework likely to be most conducive to intersectoral collaboration on health and transport. Specifically, it focuses on three

themes identified within transport planning at the local level that could provide opportunities for Health for All projects when seeking to develop work on transport. The chapter also notes where such opportunities were present in the case studies but were not capitalised on by the Health for All projects.

Chapter 9 sets out the conclusions and identifies four main themes arising through the research. The implications for health policy in England are discussed. Some recommendations for further research are made.

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Chapter 2

Influences on the development of transport policy

2.1 Introduction

This chapter addresses key debates in the development of English transport policy from the late 1940s to the mid 1990s. This has been framed in a broad inclusive way, looking not just at transport policies but also at historical influences, and wider concerns and frameworks of debate which provided the context in which transport policies were developed. These debates cover fundamental issues in terms of what social, economic and political functions transport performs. The reports, *Traffic in Towns*, and the *Reshaping of British Railways*, both published in 1963, and the influences that helped to shape the decisions of the Ministry of Transport which commissioned them, are discussed. The chapter explores values underpinning such decisions and how these developed over the decades so that transport planning in England increasingly came to be dominated by planning for greater use of private motorised transport. The experience from England is contrasted with that of Denmark and the Netherlands where priority of provision for the car was not so evident and where other modes of transport remained important in the meeting of travel needs. Key differences in the development of Danish and Dutch transport from those pertaining in England are discussed.

England has a land mass of 130,400 square kilometers and a population 46,170,000 million. It is part of the United Kingdom of which 25% is arable land, 10% forests and woodlands, and 46% permanent pastures. Only just over 1% of the UK labour force works in agriculture compared to 17.5% in manufacturing and construction and 69% in service industries (Country Listings, 2000).

A key value among politicians, transport planners and engineers in England has been the idea of progress. The assumption that the car should be the dominant and normative mode of travel built on this value. The belief in progress has its roots in the 15th century (Williams, 1976). Auguste

Compte, writing in early nineteenth century France, wrote of the inevitable evolution of human societies (Aron, 1979), and the idea of progress advanced during the industrial revolution so as to imply improvement and the idea of advancing civilisation as a 'law of history'. This was strongly related to the technological inventions of the industrial revolution which marked a turning point in history. Materials could be produced in far greater quantities than previously and often to a higher quality than by hand which, in turn, led to a sharp rise in consumption of manufactured goods as prices fell (Landes, 1980). No change in human life since the invention of agriculture, metallurgy and towns in the New Stone Age has been so profound as the coming of industrialisation (Hobsbawm, 1980). In the twentieth century, progress retained its prime sense of improvement, so that the invention of the motor car, something that could travel faster and further than all but trains (and aeroplanes) but which was more flexible in its use, fitted the idea of advancing civilisation.

Associated with industrialisation and ideas of progress is the importance of 'time-saving' which technology brought. Time saving led to great changes in expectations not only in reductions in time for previously existing journeys but also in opening up travel opportunities beyond the locality (so that, in fact, more time was being spent travelling). While such opportunities were largely confined to the burgeoning middle classes and tradesmen in the nineteenth century, from the mid twentieth century onwards widening car ownership enabled many families to travel further afield than ever before, especially for holidays and day trips. In the thirty year period between 1960 and 1990 average distance travelled per person in Great Britain more than doubled from 5,600km to 12,400 km per year (Banister, 1994). The car was promoted by the car industry as a new accessory among the labour and time saving devices which were marketed as improving what is now termed 'quality of life'. This reflected the Buchanan Report, *Traffic in Towns*, which had noted that:

“television-sets and washing machines may for the time being take precedence in the hierarchy of domestic needs, but as a longer term objective it is questionable whether anything is so much desired as a family car.” (Ministry of Transport, 1963 p. 10)

Mass car production, as first introduced by the car manufacturer Ford, enabled cars to be produced in large numbers at prices within the reach of large numbers of wage earners. The declining real cost of cars was assisted by UK government policies which ended petrol rationing in 1950 and the car purchase tax in 1953 (Hamilton and Jenkins, 1989). In addition, the rapid expansion of road capacity from the 1950s enabled more journeys to be made by car. Car ownership was further aided through the burgeoning motor industry's marketing. Increasing car ownership and use led to congested roads. The Road Lobby¹ campaigns during the late 1950s highlighted this and the need for more space for motor vehicles, hence greater road construction.

In contrast, neither in Denmark nor the Netherlands were there the same roads lobby influences pressing national governments for more road construction. In Denmark there was no domestic car manufacturing base and only a small-scale motor vehicle production industry in the Netherlands (Tengstrom, 1999). Consequently, there has not been the same potential for conflict between employment and environment policies in these countries as there has been in England.

The support of successive post-war UK Governments for road building was linked to a stated policy goal of universal car ownership, absent in both Denmark and the Netherlands. The practical consequence of this policy goal in England was that some groups in society fared better than others. For the low income household reliant on public transport the realities were markedly

¹ Hamer describes the UK roads lobby at one level as being 'an alliance of trade associations, the groups set up to promote a particular industrial sector, such as the Cement and Concrete Association... their most important function is to negotiate with government on behalf of their industries, and to lobby politicians... Behind the trade associations that support the roads lobby are some of the biggest and most powerful companies in Britain, and the world'. (Hamer, 1987 *Wheels within wheels*, London: Routledge and Kegan Paul p. 8)

different from the typical middle class male driving to work as bus frequencies fell and fares rose as passenger numbers fell. The emphasis was on building highway infrastructure which would enable car users to have increased mobility. This approach to transport planning paid little attention to the access needs of other transport mode users and how they would be affected.

The literature review explores debates about the effects of road transport policies on communities, concerns which were indicative of wider changes in public perceptions about road building by the early 1970s. A recurring public concern has undoubtedly been to ensure a decent quality of life. Quality of life as a subject of study is difficult to pin down, meaning different things to different people. The literature review explores debates about quality of life and how it has been conceptualised in relation to road transport.

A cross-cutting theme in the chapter concerns the influential role of the highway engineer in the shaping of English transport planning. This has been considerable but went largely unquestioned until the early 1970s. Then, alternative goals for transport were proposed that addressed social and environmental concerns for which engineers were not trained and had largely ignored. Other professions began to take a more detailed interest in transport, including environmental designers, social policy and public health researchers. The latter have increasingly tended to see transport as an element in a larger framework of health promoting public policies for which collaboration with practitioners in sectors such as transport is vital.

2.2 Mobility versus access

A key debate within the literature focuses on mobility and access. Both approaches view transport as a derived demand. Transport's primary function is in connecting people, goods and services. This itself allows the activities for which people travel to happen. These have been described as exchange opportunities and those who focus on access argue that people are entitled to the protection of their right to a just and equitable share of exchange opportunities

(Engwicht, 1992). Many policy and legislative declarations related to transport contain expressions such as 'accessibility', 'adequacy' or 'equity'. These imply that in the absence of state intervention certain sectors of society would have inadequate access, standards of service or be deprived of equitable treatment by the transport system (Studnicki-Gizbert, 1982). This suggests that transport is inevitably bound up with issues of social justice.

The focus of English transport policy since the 1940s has been on increasing mobility. Mobility can be measured through distance travelled but of itself does not necessarily lead to accessibility. The focus on mobility has had the effect of increasing the ability of many groups to travel - by car, plane, and, to a degree, by other forms of public transport. However, improvements in aggregate mobility, as measured through the volume of travel, do not necessarily or directly increase benefit since this derives from places reached, activities undertaken and services received (Goodwin, 1990). The down side of provision for mobility rather than access, therefore, has been a degree of inequality in outcome. This is important to note because mobility has been the dominant goal pursued by politicians, planners and engineers in England, at least until the early 1990s (Else and Trinder, 1991; Walton, 1996). This was evidenced in both England and the United States, with policy makers in the former often viewing transport policy in the latter as a model to be emulated (Adams, 1981). In contrast, Dutch and Danish transport policy was not so mobility orientated. In fact, planners in Denmark were concerned about the effects of high levels of car ownership in the United States and some other European countries and consequently proposed a plan to provide good alternatives to car use through landuse planning (Roberts, 1989).

The approach to transport planning in England, of viewing mobility as a key goal, resulted in the selective distribution of access. It can be identified through major city transportation studies where mobility of motor vehicles free from congestion was paramount. For example, in Britain major studies of the 1960s such as the West Midlands Transport Study (1964) and the Mersey

Area Land Use Transportation Study (1966) were based on predictions of rapid growth in motor vehicle ownership. They reflected those recently conducted in the USA. One, the Chicago Area Transportation Study of 1959, focused almost exclusively on the mobility and speed of car users, and to a limited degree on public transport capacities. It had stated that:

“the dominant objective of a transport plan ... is to reduce traffic friction by the construction of new facilities so that people and vehicles ... can move about within the area as rapidly as possible.” (quoted by Adams, 1981, p. 195)

2.3 The old realism verses the new realism

In England, the early 1960s onwards was characterised by the maxim ‘predict and provide’ (what might be termed the ‘old realism’), with the corollary that cities would need to be replanned, reshaped and rebuilt to accommodate the car (The Times, 1963). Both Banister (1994) and Bain (1986) note that a large proportion of transport budgets had already been committed to urban motorway projects although many had not been fully economically evaluated. The road network capacity shortfall identified by engineers and politicians was described as an engineering problem, albeit requiring some assistance from economists on economic evaluation issues. Engineers, transport planners and politicians were seen as having a monopoly of expertise on transport matters which were viewed as too complex for the general public. Such experts projected an image of the technical complexity of the task, requiring specialist highways and transport engineering skills and the production of proposals supported by comprehensive analysis.

[The] “wider implications of road building seemed not to have been discussed and the whole process from problem formulation to prediction, evaluation and implementation was viewed as a technical exercise.” (Banister, 1994, p. 25)

The clear implication was that road building was ideologically neutral. This may have been partly due to the optimism of the early 1960s that the reason for congestion was a lack of road space which could be solved by road building, to accompany the considerable building development through major housing and new town growth. With hindsight, the belief that heavy investment in an upgraded roads infrastructure would 'solve' the transport problem was naive (Banister, 1994).

Probably more important than technical reasons, there was the expectation among the politicians and local authorities that highway schemes should be built. These were viewed as an essential part of progress and the modernisation process (Starkie, 1982). The growth in car use was inevitable so it was necessary to provide sufficient road infrastructure (Grant, 1977). The confidence shown by these decision makers was reflected by the generally favourable climate of public opinion for road building during the 1950s and 1960s. The need for road building in urban areas was hardly questioned by anyone at the time, indeed there was a public outcry during the 1950s for more roads. This was connected both with the increase in motorisation and the political strength of the roads lobby (Hass-Klau, 1990). Not until the London Motorway revolt of the late 1960s was this general policy questioned (Appleyard, 1981). Furthermore, many men (especially) had returned from the Second World War equipped with the necessary mechanical skills useful for car maintenance. This helped to establish a car culture and gave them a role in overseeing what was perceived as the glamorous and prized mode of domestic transport.

Reflecting the 'old realism', a report on urban road transport, *Traffic in Towns* (the Buchanan Report), published in 1963, focused largely on accommodating the free movement of motor traffic in urban areas on the assumption that this would provide the infrastructure for most urban travel in years to come. It was commissioned by Transport Minister, Ernest Marples. *Traffic in Towns* addressed the issue of the effects of the rapidly rising levels of motor car ownership and motor vehicle use in towns and cities. It focused on the level and types of new roads infrastructure

necessary to accommodate traffic growth and, alternatively, the actions required to contain the growth of car use. Its introductory chapter concluded by noting that:

"The overriding context in which the problems of urban traffic have to be considered is the need to create or recreate towns which in the broadest sense of the term are worth living in, and this means much more than freedom to use motor vehicles." (Ministry of Transport, 1963, p. 32)

In practice, according to Hamer (1987), the Buchanan Report, welcomed by both main political parties, was a charter for road building on an impossibly expensive scale. A seventy-five mile stretch of the M1, opened in 1959, and which cost £22.5 million, was accompanied by plans for several thousand miles. These were developed by the Road Lobby and accepted by the Ministry of Transport at this time. Launching the Buchanan Report in November 1963, the Government committed itself to increasing spending on urban roads from £50 million that year to £140 million by 1970 (The Times, 1963). In effect, this was a choice to favour the car over public transport and other modes. This can be contrasted with transport planning in Denmark where, by the end of the 1960s, the transport infrastructure of motorways, inter-urban roads, and railways had largely been developed. Plans for further major road building in the 1960s were substantively reduced in the 1970s (Tengstrom, 1999). Furthermore, in neither Denmark nor the Netherlands were reports comparable with the Buchanan Report commissioned. While car ownership was rising in both countries this was accepted by national government as cause for concern due to the environmental problems of car use.

Yet, in England, the main message from the Buchanan report, which was issued to all local authorities, was that because car ownership and use would grow, and this was a legitimate desire of most of the adult population, more roads had to be built in towns to accommodate car use. Design and redesign of the built environment was a key issue in the report. An indication of

the thinking of the report was the conclusion which the Buchanan team were able to state about design, that the problem is to:

“contrive the efficient distribution, or accessibility, of large numbers of vehicles to large numbers of buildings, and to do it in such a way that a satisfactory standard of environment is achieved.” (Ministry of Transport, 1963, p. 40)

The team noted the inherent difficulty of this because of the two components, ‘accessibility and environment’, tended to be in conflict. This conflict would have been considerably lessened, however, if accessibility had been considered by modes at least additional to that of private motor traffic. However, there was no reference anywhere in the report of the implications of seeking to accommodate full motorisation on other modes (Hamilton and Potter, 1985). One caveat on accessibility for motor vehicles was the recognition of the value of a roads hierarchy and the need for sensitive treatment of certain areas such as shopping centres and residential areas. The latter could be developed, the report suggested, through the realisation of environmental areas or ‘cells’ from which through traffic was restricted by the use of certain traffic management measures. These aspects were the most important elements of the report according to some commentators (Appleyard, 1981; Hass-Klau 1990; Banister, 1994). Indeed, the notion of environmental capacity associated with this idea was applied in other European countries through the development of traffic calming, as in the former Federal Republic of Germany, yet largely ignored for over twenty years in the UK (Davis, 1992a). A minor exception to this came from some street improvements incorporated into General Improvement Areas associated with a 1969 Housing Act, although traffic aspects were of low priority (Beth and Pharoah, 1988; Davis, 1989). Denmark and the Netherlands were among those European countries which drew on *Traffic in Towns* in the development of slow speed streets where greater emphasis was given to the residential function of the street than to the through movement of motor traffic.

Views as to the emphasis placed by the Buchanan team on the need to control car use are divided. At the time, the report was widely welcomed as opening the debate about towns and traffic growth to the general public (Vickers, 1965). In the field of transport planning there was also some notable criticism of *Traffic in Towns*. A substantive appraisal of *Traffic in Towns* was undertaken by the economists Beesley and Kain (1964). Central to their criticisms was that, on the one hand, Buchanan felt unable to:

“form a judgement of the opportunity costs of the total investment proposed, and on the other, regards the returns to investment, for motor vehicle users at all events, as approaching infinity.” (Beesley and Kain, 1964, p. 175)

Writers such as Starkie (1982) and Hass-Klau (1990) both noted that Buchanan's writing during the late 1950s was very critical of urban car use, as exemplified in a 1958 book *Mixed Blessings*. In this he discussed the impact of the motor car, including pollution, and of the need to segregate the pedestrian from other traffic in order to improve conditions for the former. Similarly, Mogridge claimed, in *Travel in Towns* (1990), that Buchanan's sentiments 'pre-echo my own' in that both were concerned with the use of limited road space in urban areas and both identified the importance of the role of public transport in this regard. Other commentators on Buchanan's role in the 1963 report view him as an arch advocate of the car's beneficial and dominant role in post-war society (Adams, 1981; Hamer, 1987; Hillman, 1993).

Importantly, it was Marples and Ministry of Transport officials who chose to interpret and select from *Traffic in Towns* a perspective that fitted with their own viewpoint. It is notable, for example, that the Ministry of Transport issued a film about the report which was shown widely at public cinemas and which promoted the view of the need for major urban road building programmes. The Ministry of Transport had never previously sought to publicise reports through this medium (Hamilton, 1997).

Many commentators have noted that the assumption of major benefits to be gained from a policy shift towards mass car ownership had critical flaws (Bendixson, 1974; Renner, 1988; Roberts, 1990). In fact, the Buchanan Report had acknowledged that cities with populations of 300,000 or more could not provide for the movement of all of its population by car no matter how many roads were built (Hamilton and Jenkins, 1989; Mogridge, 1990). Yet the value judgements of transport planning of this period in England about priorities and the limits of concerns for equity were reflected by policies which tended to ignore or treat as minor problems issues arising from mass car ownership such as the fact that the majority of the population were not car owners (Hillman, Henderson and Whalley, 1973). In the early 1960s, moreover, there was public support for road building. The early and mid 1960s can be characterised as a period of overwhelming emphasis on accommodating the motor car (Trinder et al, 1991). This waned to some degree during the early 1970s, principally because of the oil crisis but this event had more of an influence in countries such as Denmark and the Netherlands in encouraging greater efforts at energy conservation and less reliance on private motorised transport than it did in England (Jamison et al 1990). Indeed, private transport embodied major themes of the Conservatives 18 year administration from 1979-1997, notably freedom and choice. Previous Labour administrations since the 1950s also largely welcomed widening car ownership and road building.

The era of government support for road building and minimum restraint on the use of private motorised transport subsequently weakened during the course of the early 1990s in the wake of the 1989 revised Road Traffic Forecasts. The Forecasts were released on the same day in May 1989 as a Transport White Paper, *Roads for Prosperity* was published which announced a £12 billion roads programme for the coming decade (Department of Transport, 1989). The Forecasts estimated that road traffic levels would increase by between 83 and 142 per cent by 2025. While the White Paper was welcomed by the Roads Lobby (Tolley, 1990) over the next eighteen months or so it came to be viewed by many within the road transport policy field (and increasingly

also by growing numbers outside), to be inconsistent with what could be supported by the road network (Association of County Councils, 1991). This view developed principally because even with the small expansion of network capacity that the 1989 roads programme envisaged, supply could nowhere near meet predicted 'demand', even in the countryside (Countryside Commission, 1992). Goodwin has noted that it became clear during 1989 and 1990 that in towns there simply was no way that road capacity could be expanded at rates which would match even the lower traffic growth forecasts. Moreover, this was a matter of arithmetic, not politics. This recognition has been termed the 'new realism'. The outcome of this was increasing agreement across major political parties for demand management as part of urban transport policy.

"This means that demand will have to be moderated to meet supply. This is the core transport planning axiom of our time, and it will effect *everything* else in the transport sector of the economy." (Goodwin, 1994 p. 5)

By the mid 1990s the rhetoric of demand management and reducing the need to travel had become policy goals (Departments of Transport and Environment, 1994). In 1995, the then Secretary of State for Transport, Dr Mawhinney, launched what he termed 'a new debate about transport', highlighting the 'choices which must be made'. He contextualised his comments with regard to the work of the Secretary of State for the Environment's responsibilities for sustainable development (Department of Transport, 1995). This period of change within English transport planning, from the beginning of the 1990s, coincided with, and was influenced by, increased attention being given to environmental issues generally. This was the case both inside as well as outside government, and the concept of sustainable development was a particularly powerful influence. Sustainable development provided an additional rationale for a change in transport planning away from 'predict and provide' to 'demand management'.

The 'new debate about transport' was reflective of a climate more favourable to the promotion of alternative modes to the car. Policies previously ignored by government were being initiated by the mid 1990s by the Department of Transport as part of a broad package of measures required for the deployment of demand management. The Government launched a National Cycling Strategy (Department of Transport, 1996), issued air quality guidance and also a consultation paper on a walking strategy. The Department of Health also produced a Strategy Statement on Physical Activity with a focus on routine activities such as walking and cycling as part of daily living (Department of Health, 1996). Government support was also forthcoming for a Private Members Bill which subsequently became the Traffic Reduction Act (1997), albeit with targets for central government removed during the drafting stage. In contrast, road infrastructure funding declined substantially. Such change, it has been suggested, implied a recognition of the need to provide the means by which demand management could be applied; greater efforts to develop sustainable transport practice; and most importantly, a sea-change in Government thinking (Goodwin, 1994, University of Westminster, 1996; Walton, 1996).

2.4 Engineering culture versus environmental planning

From the 1950s to the 1970s the development of transport policy and practice in England was viewed by many observers as being associated with several discrete disciplines (Healey, 1977; Hall, Hebbert, and Lusser, 1993). On a day to day basis these were largely seen to be the domains of highway engineers and transport planners. In this period road transport planning was effectively reduced to planning for road construction for the benefit of private motorised road users. The traffic engineer focused primarily on traffic demand, engineering feasibility, and construction, maintenance and operating costs (Healey, 1977). The central task was to reduce or remove the impediments to the free flow of motor traffic, and with respect to public investment, there were two main agents. One was the engineer who was responsible for road construction and maintenance, and the management of the road system; the other was the operator who controlled public planning and management. Economic considerations were concerned with

allocative efficiency. Both engineering and economics led to a concentration on the average benefits of infrastructure projects for study areas considered as a whole, not upon the detailed analysis of which individuals or groups gained or lost (Banister and Hall, 1981).

A range of techniques were developed, from urban transport models, modal split, trip generation, origin and destination data, and cost-benefit analysis in order to prepare rational plans for optimum transportation systems (Healey, 1977). Transport planners and traffic engineers pursued good 'grades' of vehicle flows with single-minded determination. These were both handy and legally defensible. They were embraced without reservation. What had been the overriding concern of planners and engineers was extended to the policy makers (Ewing, 1995). Irrespective of the intentions of the Buchanan Report team, it has been argued that its findings were interpreted by many in transport engineering and planning as endorsing such a perspective (Hass-Klau, 1990). Hass-Klau, herself trained as a traffic engineer, notes that:

"there is no doubt that the Report suggested road-building but it was to be done in a sensitive way. The problem was that most transport engineers who could have put these ideas into practice did not have this sensitivity. How could they, they had never been trained for it?" (Hass-Klau, 1990, p. 175)

Moreover, the burgeoning motorways and trunk road system was viewed as progress by these experts, who saw few, if any, long term negative environmental, social or political costs. A reflection of this in the 1960s, an era of urban motorway building of mainly dual carriageway standard, was to be found in cities such as Coventry, Birmingham and Liverpool whose politicians enthusiastically sought to implement cities for cars. Leeds was happy to promote itself as the 'Motorway City of Europe' (Hamilton and Jenkins, 1989). All these cities had, in fact, been selected and given funds by the Government after the publication of the Buchanan Report to try

to apply major rebuilding programmes in order to provide space for increased car use on a scale not previously attempted in the UK.

The traffic and highways engineers were particularly powerful since it was they who could put ideas into practice. This power was to become particularly important when planners (whose training had links with architecture and placed value on the built environment) began to develop ideas for restricting traffic and pedestrianisation (Hass-Klau, 1990). Often such ideas were inspired by traffic restraint schemes introduced on the continent in countries such as the Netherlands, West Germany, Sweden and Denmark (Tolley, 1989). It was not until a period beginning in the early 1970s that the engineer's perspective began to be challenged by those more concerned with the equitable distribution of transport resources (Sutton, 1988). The dominance of the engineer in planning was epitomised in the opening of the Westway in London. It has been noted in retrospect that the insensitivity of engineers to a scheme which passed within a 100 metres of housing seemed typical of the cavalier approach of highway engineers to existing structures (Banister, 1994). Despite a major campaign against the Westway and disruption of the opening ceremony in August 1970 by anti-road protesters (Hamer, 1987) there was considerable support for the scheme at the time among professionals (Starkie, 1982).

In England during the 1970s, the growth of the environmental movement signalled growing concerns about the social and environmental impacts of major highway construction and rising traffic levels. The road building programme was also becoming a victim of its scale by adversely affecting enough people across the country to swing public opinion away from the previous widespread support it was able to tap into in the 1950s and 1960s. In Europe and North America, issues of transport and access opportunities were being more actively tested. In Britain this was expressed particularly through community group involvement at Public Inquiries into road scheme proposals (Grant, 1977; Appleyard, 1981). The official response was twofold. One was to focus some attention on the provision of public transport in meeting 'a reasonable level of personal

mobility... for those who do not have an effective choice of travelling by car' (Department of Transport, 1977), and another to allow greater involvement of the public in decision making, principally through consultation at public meetings where plans would be outlined.

Social and environmental concerns were officially recognised to be issues that needed addressing, but progress 'up the ladder' towards mass car ownership remained the policy goal. Official confidence about the lack of disbenefits of private motorised transport continued. For example, in giving evidence to the Clean Air Council in 1979 the Department of Transport felt confident in stating that:

"the effects of pollution by motor vehicles can be summarised: there is no evidence that this type of pollution has any adverse effect on health." (quoted by Green, 1994, p. 3)

Concern with infrastructure investment, particularly new roads, has been found to be the main issue for transport policy-making in England at the local level, followed by and closely related to traffic flow (Else and Trinder, 1991). Health impacts which were studied were largely confined to noise and air pollution, and road traffic injuries, using numeric measurement methods. This reflected how most efforts at providing a theoretical foundation for transport planning were directed at finding methods of analysis with practical measures, usually quantitative, such as cost benefit analysis with its particular 'output' of savings in time (Sharp, 1973). In English transport planning, qualitative assessments, which might have captured public unease about the social effects of increased motor traffic and road building, are conspicuous by their absence.

This quantitative approach has been the focus of powerful critiques in recent years, for example, of road safety policy as an outcome of transport planning which has been focused on risk avoidance and the modification of lifestyles. The danger posed by the most dominant form of motor transport, the car, to users of other travel modes, has been largely masked by a focus on

risk management. Most measures have been targeted at pedestrians and cyclists (largely victims of traffic crashes) (Adams, 1985; Wolinski, 1994). As such, safety on the road is:

“and always has been, a question of who defers to whom - of which road users are allowed how much space, and what effect they are allowed to have on the safety of others. Discussion about appropriate measures to be taken for ‘road safety’, whether in engineering, education or enforcement, is really a form for the parade of views supporting the freedom of one or other group.... supporting an unnecessarily dangerous and discriminatory status quo.” (Davis, R. 1992, p. 117)

The dominance of the engineering role in transport planning was also epitomised by the first traffic calming schemes in Britain in the late 1980s, as these were overwhelmingly engineering schemes in contrast to the environmentally sensitive traffic calming developed elsewhere in Europe (Tolley, 1989; Davis, 1992a). Such schemes were implemented in order to reduce accidents as part of a government target to reduce road traffic casualties by one third by the year 2000, but not necessarily to improve amenity (Beth and Pharoah, 1988). More generally, an outcome of this dominance has been that the most prominent shaping of public policy in new developments has been the:

“wasteful and excessive standards imposed by engineers in the interests of vehicle flow and service maintenance. We have the worst of all worlds: undersized houses amidst oversized suburban roundabouts, car parks, mown verges and turning circles.” (Hall, Hebbert, and Lusser, 1993)

Such issues have been addressed by a working group of the Transport Planning Society, which was established in 1994. The working group has noted that English transport planning has been slow to embrace issues, such as the environment or demand management, which did not fit

easily with the professional traditions or involved compromises in the way in which they related to the wider political and policy-making process. The professionals involved too often saw transport challenges in terms of what they traditionally had to offer, rather than what was needed. 'How many traffic engineers have had training in traffic calming techniques or have skills in urban design or environmental appraisal?' (Bayliss et al, 1996).

Environmental issues made a significant impact during the early 1990s, with public consciousness about damage inflicted on the environment peaking in about 1990/91. While the intensity of concern and media interest declined thereafter the concern plateaued at a level which was far higher than prior to the 1990s. This is evidenced both by continued high polling for people describing themselves as 'very worried' about transport-related problems, in response to a questionnaire regularly conducted by the Department of the Environment (Department of the Environment, 1994; Maddison et al, 1996) and through increased membership of environmental groups (Friends of the Earth and Greenpeace both claimed memberships of over 200,000 in the mid 1990s). Whereas a few years earlier concern about the environmental impact of roads would have been regarded as being the focus of a small minority, by the mid 1990s it was seen as a more general concern, spread across all social classes. Furthermore, background research which informed the 1996 Transport Green Paper found that environment and health concerns ranked high among public concerns (University of Westminster, 1996).

Environmental pressure groups and researchers have published a large volume of reports since the late 1970s on the need for more rational use and conservation of natural resources. Their efforts were considerably aided by other reports and events. The Bruntland Report 'Our Common Future' (World Commission on Environment and Development, 1987) gave widespread credence to the concept of environmental sustainability and provided a key reference point for future environmental campaign work. It stemmed from international concerns at government level about environmental degradation. Gro Harlem Bruntland, Prime Minister of Norway in 1983, was asked

by the Secretary-General of the United Nations to establish and chair a special, independent commission on the environment. She was approached to chair the commission because she was the only Prime Minister with a background as an environment minister. The subsequent World Commission on Environment and Development was asked to formulate 'A global agenda for change'. Among other tasks, it was charged with proposing long-term environmental strategies for achieving sustainable development by the year 2000 and beyond (World Commission on Environment and Development, 1987).

The report was highly influential, stimulating the publication of a European Charter on environment and health by the World Health Organisation (WHO, 1990). It was also instrumental in encouraging the British Government to take stock of Britain's environmental heritage and produce a White Paper 'This Common Inheritance' (Department of the Environment, 1990) which laid the foundations for the Government's 'Sustainable Development Strategy' (H.M. Government, 1994) in the wake of the Earth Summit in Rio de Janeiro in 1992. One of the most influential reports was produced by the Royal Commission on Environmental Pollution (Royal Commission on Environment Pollution, 1994). Taking evidence from hundreds of organisations and individuals, the Commission undertook study tours which included America, Asia and continental Europe in compiling a damning indictment of government transport policy. The Commission's findings were similar in many respects to much of the materials previously published by environmental pressure groups, among others. In particular, it highlighted the conflict between official forecasts of a doubling in road traffic by 2025 and a road building programme which would not stop traffic congestion from getting worse.

In contrast to the transport policy environment in England, environmental concerns have been integral to both Denmark and the Netherlands' policies over the past 30 years. There has not, therefore, been such a struggle between engineering and environmental cultures. In these countries the state institutionalised environmental concerns from early in the 1970s and this has

been a significant if not dominant policy driver in both countries, while road building and provision for private motor transport have been far less prominent. This meant that the development of transport policies in these countries followed a markedly different path from that pursued in England, having been increasingly environment-led from the early 1970s.

Denmark

As a relatively small nation, Denmark is particularly dependent on its natural resources for jobs and wealth creation and the strength of the agrarian sector of the economy is witness to this. It has a land mass of 42,394 square kilometres of which 60% is arable land, 10% forests and woodlands, 5% permanent pastures, and a population 5,300,000 million. Only 4% of the labour force work in agriculture compared to 25% in industry and 71% in service industries (Country Listings, 2000). It was only from the late 1950s that the industrial share of the GNP exceeded that of agriculture (Jensen and Jorgensen, 2000). This is reflected in concern for environmental issues. Since the early 1970s there has been a strong environmental movement which has been successful in influencing government policy. Environmental groups include NOAH (Danish branch of Friends of the Earth); the Society for the Conservation of Nature (SCN), and Greenpeace. SCN, the largest, had a membership of 250,000 in 1988, some 15% of the adult Danish population (Jamison et al, 1990). Pressure from such groups helped to ensure that an integrated approach to environmental issues was institutionalised into government policy from the early 1970s. During this time there was a strong focus on pollution issues, and much of the legislation during the 1970s, drafted through Denmark's first Ministry for the Environment, which was appointed in 1971, focused on pollution control (Jensen, 1984).

Since the 1970s, the development of Danish environmental policy helped to mobilise business organisations, and political parties, into acceptance of the environment as a political problem. The political and administrative responses to this successful mobilisation were shaped within the traditions of cooperation and consensus, typical of Danish political life (Tengstrom, 1999). For

example, business organisations, which include many companies in the transport sector of the economy, are represented by the Federation of Danish Industries. The Federation's stance from the early 1970s to the mid 1990s was not to question the need for environmental legislation but to seek to influence its drafting, where it could, in order to moderate the impact (Andersen, 1997). In addition, the absence of a domestic vehicle manufacturing industry in Denmark meant that there was no strong lobby for road building, unlike in England. It has been claimed that this, together with a high import tariff on motor vehicle imports, acted as an effective means by which car ownership has remained relatively low compared with other western European nations (Pharoah and Russell, 1989).

At the end of the 1960s, much of the Danish transport infrastructure of motorways, interurban roads, and railways in place was largely developed so that by the mid 1990s very little more infrastructure had been built. Part of the reason for this was that the Copenhagen region, according to Jensen and Jørgensen (2000), was largely deprived of funds as a result of national politics during the 1970s and 1980s, with the perceived predominance of the Copenhagen region being countered by the introduction of tax exemptions, and inducements for development elsewhere, especially in western Denmark. This contributed to the relatively slow growth in private motor transport's share of travel, and in Copenhagen itself a slight decline in car travel. Yet the decline in transport infrastructure development was also in no small part due to growing public and government concerns for the environment, reinforced by the first energy crisis in 1974 and the consequent recession in the Danish economy. At this time Denmark's imported oil accounted for 88% of the total energy supply, considerably higher than in any other Scandinavian country (Jamison et al, 1990).

As a result, substantive efforts were made by national government to reduce impacts such as casualties, pollution and energy consumption. Attention was increasingly focused on better use of existing investments and resources including the road and rail networks. Specific actions

included the widespread introduction of low speed limit zones (20mph and 8 mph limits), integration of public transport systems, new legislation, and measures to increase the proportion of freight carried by rail (Flyvbjerg et al, 1990). Cycling, which had remained a popular mode of transport in many Danish towns since the 1950s, gained increasing attention as part of the focus on resource efficiency. As infrastructure for cycling, such as cycle lanes, had mostly been retained during the 1950s and 1960s there was already a basic network which could be extended and which helped to sustain a growth in cycle use from the 1970s. An increase in priority for cycle planning from the late 1970s has been related both to the oil crisis and successful lobbying by the Danish Cyclists Federation (Flyvbjerg et al, 1990).

The emphasis of discussion in the literature on Danish transport planning has, therefore, largely revolved around the increasingly coordinated programme of policy actions implemented by national government from the 1970s (eg Flyvbjerg et al, 1990; Andersen, 1997; Tengstrom, 1999, and Chapter 6).

The Netherlands

Concern about transport and the environment in the Netherlands is noted for being more evident than in many other European countries (Kroon, 1990). This partly stems from a history of battling with the elements, especially the eroding coastline (Haq, 1997), and the building of dikes to reclaim and protect coastal land. More than half of the country is below sea level (Hoffman, 1990). It has been claimed that this factor has helped many Dutch people to feel a close tie to the natural environment since the entire landscape has been shaped by human labour (Jamison et al, 1990). Indeed, low lying land, a high water table, and the need to develop approaches to lessening the threat of flooding has had a determining role in land use policy development. The scale of the problems relating to the risk of flooding may be hard to comprehend in the United Kingdom where building is carried out largely without the need to transport large amounts of sand, soil and other load-bearing materials prior to construction. Yet for much of the building work

that takes place in the Netherlands such activity is an essential prerequisite (Carter, Oxley and Golland, 1996). Global warming, and the consequent threat of rises in sea level and flooding of low lying land has provided an added incentive to reduce carbon dioxide emissions, a major transport sector pollutant and contributor to global warming (Rietveld, 1993).

The Netherlands has a land mass of 33,889 square kilometers of which 25% is arable land, 8% forests and woodlands, 25% permanent pastures, and a population 15,892,000 million. Only 4% of the labour force work in agriculture compared to 23% in industry and 73% in service industries, similar to the labour force occupation profile in Denmark (Country Listings, 2000). Yet with a population three times that of Denmark and a slightly smaller land mass, pressures on land use are greater. The Netherlands is, in fact, the most densely populated country in Europe.

The lack of a significant motor manufacturing industry and roads lobby, and consequent industry pressure for road construction, helped the bicycle to remain an important mode of transport for many Dutch citizens after World War II. Nearly 30% of trips are made by bicycle despite strong growth in motor vehicle ownership from the 1960s (Rietveld, 1993). Shipping also remained important for economic development, mainly as a result of its physical geography. Its location at the North Sea and the Rhine in the middle of a highly industrialised hinterland was crucial to the development of Rotterdam as the biggest port in the world. High volumes of freight transport takes place by ship via a system of rivers and canals within the country, which also extends to the neighbouring countries of Germany and Belgium (Jansen et al, 1990). As a result of such factors, the Netherlands has not become so dependent on road freight transport as many other Western European countries.

By the mid 1970s, responding to environmental pressure groups and public concerns, the national Government decided that coordination between the ministries responsible for transport, spatial planning and the environment was necessary in order to address the environmental

concerns. Since that time policy integration has become commonplace, with direct linkages in policy documents being made between the various policy fields concerned with transport impacts (Dekker, 1994).

The environmental movement which developed during the 1970s and which initially focused on direct action and challenges to government had, by the end of that decade, changed tactics and was prepared to meet with government. By the mid 1970s environmental policy measures had begun to have an impact on policy, including the implementation of the first 5 year transport plan from 1976-77, and the pressure groups had developed expertise on environmental issues which were recognised as being helpful to government. Environmental pressure group membership also indicated the strength of concern about the environment. In the mid 1970s membership of the four main environmental groups totalled nearly 350,000, rising to 665,000 by the mid 1980s (Bresser and Plettenburg, 1997). This meant that a higher proportion of the Dutch population were members of environmental groups during the mid 1970s than found in England twenty years later.

As a consequence, and strikingly similar in many ways to the focus of much Danish transport planning literature, many reviews of transport planning in the Netherlands have focused on the development of national government policies (eg Kroon, 1990; Jansen et al, 1990; Vleugel, van Gent, and Nijkamp, 1990; Rietveld, 1993; Haq, 1997; Tengstrom, 1999) and analysis of the plethora of policy papers produced since the 1970s (see Chapter 5).

2.5 Individual choice verses social policy

Much of the criticism of post-war English transport planning policy has been focused on its lack of social content such as failing to intervene to protect the needs of vulnerable groups. Jones has noted the links between transport and poverty. Certain groups such as women, children and disabled people, face problems of access (Jones, 1996). She contends that because transport is

a major source of social division, transport policy should be seen as part of the social welfare agenda. In similar vein, Cahill reports on the increasing centrality of the car in travel mode decisions because the dominant image of transport, guided by government policy, is that it is a matter for the individual (Cahill, 1994).

For much of the twentieth century car ownership largely reflected the values and interests of those with most power in society, those with responsibility for transport policy (Heierli, 1993). Car ownership increases inequalities in the ability to meet access needs as shops and facilities have become more dispersed with landuse changes and are orientated towards car users. This change itself has been triggered by increased car ownership and use. Car owning households are, for example, able to buy in bulk at superstores (which have tripled in number in the UK between 1986 and 1997 alone) and which can offer discounted prices. In contrast, the number of independent food retailers fell by 40% during the same period. 'Corner shops', often found on housing estates in poor districts where car ownership is low, have been found to be up to 60% more expensive than superstores (Piachaud and Webb, 1996).

The impact of increasing car ownership has been particularly adverse for poorer households. Banister has noted that the desire to maintain car ownership once attained is strong, to the extent that the family food budget is likely to be squeezed before the car is sold (Banister, 1980). This may be particularly so for those living in rural areas due to longer distances generally travelled in order to meet access needs, including work, and a paucity of alternative transport which has contributed to a disproportionately large increase in car use in rural areas relative to population size.

In 1975 Hillman set out six key social goals within a framework of public policy which seeks to improve the quality of life for all members of society. These were:

- the furtherance of equity;

- the maintenance of maximum personal freedoms compatible with similar freedoms for all members of society;
- the abolition of causes of unnecessary suffering;
- responsibility to posterity;
- the minimisation of waste; and
- the improvement of the social and physical environment.

In a 1993 commentary on progress since 1975 in England, Hillman could find no improvement over the intervening 18 years; indeed he noted all trends appeared to be heading in directions incompatible with attainment of such policy goals (Hillman, 1993).

Many of Hillman's social goals are identified, at least in general terms, by others (eg Tolley, 1990; Sherlock, 1991). More generally, social goals may be addressed as quality of life issues. Indeed, Banister notes the increasing role played by transport in determining who gains access to what opportunities and to social as well as economic wealth. As such transport forms an important part of every person's quality of life (Banister, 1994). In this sense social policy needs to be orientated towards every day concerns such as access to ensure people are not excluded. Access, as Cahill has noted:

"needs to become a key term in the vocabulary of social policy for it is important for so many of the users of services; older people, disabled people, children... the dimensions of poverty and inequality can be carried through into the analysis of social life." (Cahill, 1994, p. 5)

Broadening car ownership has, however, been promoted by all major political parties in England with an implicit assumption that there will be a transition to universal car ownership, that is everyone who wants one and is eligible has access to one, but that this process takes time. The

wealthy gain first but eventually all climb the ladder of car ownership. As Anthony Crossland, Secretary of State for the Environment with responsibility for transport stressed in a 1976 White Paper:

“Car ownership ... should increase, for personal mobility is what people want, and those who already have it should not try to pull the ladder up behind them.” (Department of the Environment, 1976a, p. 4).

The idea that everyone is entitled to what the most fortunate enjoy today is a belief that has understandable appeal for politicians and electorates of all ideological colours. Yet the reality was that the majority of the population would never have direct access to cars (Adams, 1981; Goodwin, 1990; Hillman, 1993) and that those who lost most from a policy centred on car travel were also those who already suffered from the greatest travel problems. Thomson, who studied many major cities' transport systems during the 1970s, noted that 'most governments regard the general desire for car ownership as irresistible', despite also reporting that 'with few exceptions, all [cities] suffer from severe traffic congestion' (quoted in Adams, 1981).

Gross inequalities of access resulted from post-war transport planning for a number of reasons. It has been argued that erroneous assumptions about rising levels of economic growth, and hence more rapid car ownership and the attainment of the calculated vehicle ownership 'saturation' level, were made during the 1960s and 1970s (Grant, 1977; Hamilton and Jenkins, 1989; Hass-Klau, 1990). Use of 'the household' as a homogeneous category of car users also failed to address how car use would be allocated within households. A result was that the massive investment in road construction in the 1950s and 1960s was advantageous to those men who could afford to drive to work, while women struggled with the outcome of diminishing investment in public transport to meet complex access needs (Pickup, 1989) amidst growing concerns for personal safety (Greater London Council, 1986; Atkins, 1989).

Children, the elderly, the poor, and women lose most as the viability of the modes they are most reliant on, walking, cycling and public transport, are undermined in various ways by an increasing resource allocation favouring private motorised transport. Moreover, it has been precisely these groups, highly dependent on walking, cycling and public transport who have had little, if any say, or influence over transport planning decision making which determined accessibility. In addition, changing travel demands and patterns of mobility during a lifetime inevitably mean that many adults now with high levels of accessibility as a result of car use will lose out as they age given the inadequacy of provision for alternative modes. The current generation of young car drivers, who have grown up with mass car use are likely to seek to retain this use for as long as possible but are still likely to need public transport at some stage, if only as infirmity approaches.

Low income households are also more likely to be reliant on public transport. Expenditure on bus travel is relatively much more important to the poor than to the rich. It was partly for this reason that local authorities such as South Yorkshire and the Great London Council used fares subsidies as a tool to ensure adequate levels of mobility to disadvantaged groups (Goodwin, 1990). As public transport use has declined since the 1950s poorer social groups have suffered most from this and particularly from the effects of bus de-regulation in 1986 (Nicholl, Freeman and Williams, 1987; Hamilton, Jenkins and Gregory, 1991).

After deregulation of bus services in 1986, when bus fares rose by 250% in South Yorkshire, the unemployed and the retired reduced their bus journeys by over 62% and 60% respectively compared with 37% reductions for those in work and 48% reductions for school children. Additionally, social support networks suffered as travel to undertake informal caring roles were more difficult to make. This resulted in increases in requests for statutory support services including home helps (Sheffield City Council, 1986). Bus de-regulation is likely to have made caring responsibilities and social support more difficult, including provision of child care, involving

increased complexity in individual household scheduling, a burden borne particularly by women (Grieco, 1989).

Low income households suffer particularly from communication deprivation in terms of information about public transport availability in a changing transport environment, largely reliant upon physically available information (Grieco, 1989). Women as carers have particular difficulties in accessing health services, especially because bus services tend not to fit in with hospital visiting hours (Hamilton, Jenkins, and Gregory, 1991), especially for those living in rural areas (Hirst, 1996).

2.6 Quality of life debates in the transport sector

In the UK transport literature, quality of life is sometimes implied to be related to improving accessibility by all modes (Royal Automobile Club, 1998). More generally, however, there is a presumption that a good quality of life comes from controlling and ameliorating the impacts of motorised transport including health effects (eg Royal Commission on Environmental Pollution, 1994; Hazel, 1997). Within the transport literature there is, however, relatively little analytical assessment of what constitutes quality of life.

A review of common transport texts reveals that 'quality of life' is largely not of itself an issue for discussion although those same texts often carry passing references to quality of life as if it is an uncontested concept. The Royal Commission on Environmental Pollution lists quality of life as one of the objectives for a sustainable transport policy and then refers to quality of life only occasionally as a generality in its 325 pages. Objective C is:

"To improve the quality of life, particularly in towns and cities, by reducing the dominance of cars and lorries and providing alternative means of access." (Royal Commission on Environmental Pollution, 1994, p. xiv)

One of the most active researchers and authors on the subject of environmentally friendly and sustainable transport during the 1980s, the late John Roberts, addressed quality of life in a similar fashion. In discussing 'user friendly cities', Roberts comes close to an assessment of what people want from cities in terms of quality of life when he asks the question 'What characterises cities where people want to be?'. He states this as being where high quality housing is available and is 'located within easy reach of jobs and all the support services for a full life - for all'. In addition there should be ease of movement without fear of assault, with minimal accidents involving people or vehicles, noise levels that do not inhibit conversation, and minimal vehicle emissions (Roberts, 1989). Buchan (1992), in setting out a new system for assessing transport schemes, bases the system on what he views to be quality of life objectives. He claims to provide a comprehensive list. However, and as with other transport writers, Buchan does not directly address what he perceives to constitute quality of life nor provide any substantive information as to how it can be assessed.

In recent years quality of life has been a focus within the critique of transport as a barometer of economic growth. Traffic growth as a quantitative measure, has been closely associated with, if not used as a barometer for, economic growth. The link between traffic growth and the economy was emphasised in the 1989 Transport White Paper (Department of Transport, 1989). The economic benefits of road building, said the report, would result from reducing levels of congestion, the scale of which was anticipated to increase significantly in the light of the revised National Road Traffic Forecasts.

In contrast, in the Netherlands the rise in car ownership from the 1960s in the most densely populated country in Europe intensified concerns for the environment and the need for government programmes of action as traffic congestion and pollution became more prevalent. When opinion polls in 1970 had shown that 71% of the Dutch population 'strongly agreed' and

25% 'agreed' with the view that the government should take severe measures to control environmental pollution it was a stimulus for action by the national government which proceeded to strengthen the influence of environmental policies (Jansen et al. 1990).

In England serious doubts as to the quality of life and health effects of road transport were being raised more consistently from the early 1990s (Ekins, Hillman, and Hutchinson, 1992; Popay et al, 1993). For example, in calling for an environmentally sustainable transport policy, the Institution for Environmental Health Officers has warned that health and environmental quality are being sacrificed in the attainment of ends which are no longer a benefit to society at large.

"We must recognise that there is a point beyond which human health and protection of the environment can no longer be traded for purely economic gains. There is a point where economic gain no longer improves quality of life, but reduces it. With regard to transport use that point may well have been reached." (Institution of Environmental Health Officers, 1993, p. 61)

These debates are essentially a continuation of those which began in the 1960s with work to develop social indicators that would place value on less quantitative aspects of life than can be achieved through calculations of economic activity as measured through GDP, as will be discussed in Chapter 3 which addresses wider debates about quality of life.

Improvements in quality of life have been presumed by transport planners, engineers and politicians in England to flow from policy and practice but little attention has been given to considerations of how any quality of life benefits are distributed across the population. Transport officials and politicians have placed most value on aggregate quantitative data such as traffic flow and accident statistics, and pre-determined and standardised questionnaires. These cannot convey, however, public attitudes, reasons for choices, nor how health and wellbeing are

influenced through transport policies. 'Soft' data such as public perceptions and voiced concerns have been viewed by such groups as subjective preferences and inherently of less value.

The changes since the 1970s within social science research to supplement economic data about a country's development with subjective indicators has largely failed to be applied within official thinking relating to English transport policy. Attempts to use indicators of livability and the possibilities of drawing on these to develop Buchanan's ideas of environmental cells, and in applying the concept of environmental capacity limits for roads (Gilbert, 1988; Davis, 1992b), has largely been ignored.

2.7 Transport and health: from sectoral isolation towards collaboration

In the period up to the mid 1990s, the road transport sector collaborated little with health professions beyond the involvement of environmental health officers in the monitoring of air and noise pollution and the health services with regard to traffic casualties. Indeed, transport has been described as a hidden health issue (Jones, 1994). With the dominant view in both the health and transport sectors of three quantifiable effects of transport on health there was little information to encourage professionals from disciplines within either sector to consider other possible affects on health. Moreover, there is little in the literature to suggest that health concerns have played a significant role in influencing transport policy in either England, Denmark and the Netherlands. From the 1960s until the late 1980s the relationship between transport and health was almost universally focused solely on three quantifiable effects on health. In England the Buchanan Report (Ministry of Transport, 1963) discussed the links. Most prominent, the report noted, were road traffic fatalities and injuries because of the many thousands of lives lost or lives permanently impaired. Secondly, noise pollution, partly because it is measurable but also because some effects are tangible, such as lost sleep and hearing loss. Thirdly, air pollution which, although the Buchanan Report noted that 'engine fumes do not yet rank as a major cause of atmospheric pollution', did refer to the carcinogenic properties of 'fumes' and also smog

causing 'eye and throat irritants'. This limited perspective on health impacts is reflected in later documents such as the UK manual for Roads and Traffic in Urban Areas (Institution of Highways and Transportation/Department of Transport, 1987), the Danish White Paper on Transport 'Traffic 2005' (Ministry of Transport, 1993) and the Dutch Second Transport Structure Plan (Second Chamber of the States-General, 1990).

Likewise, there is little evidence in the literature of any significant calls for change voiced from within the health sector prior to the late 1980s, other than support for further efforts to reduce traffic injuries. For example, in terms of air pollution in England, respiratory specialists have tended to refer back to the passing of the 1957 Clean Air Act which improved conditions to the extent that the Clean Air Council was abolished in 1979. The Medical Research Council's Air Pollution Unit closed in 1980 with the result that the monitoring network was largely disbanded (Green, 1995). Ironically, it was public concern rather than pressure from the medical profession which led to the Clean Air Act (Bates, 1996). The success of reducing smoke and sulphur dioxide levels in the main British cities led, however, to complacency in many areas about the changing nature of air pollution due to the growth of motor traffic (Holman, 1989). Research into the affects of air pollution increased significantly in Europe (and elsewhere) from the late 1980s (for example, Dockery et al, 1993; Katsouyanni, 1997).

There was one significant exception to the limited concerns about health effects of motor transport. On the issue of lead in petrol health professionals did take decisive action. Indeed, the UK was at the forefront of action in Europe to reduce the health threat posed by leaded petrol. In 1971 the Government was advised by the Chief Medical Officer of the Department of Health that it was desirable that levels of lead emissions from vehicles should not rise, and if possible, should be reduced. The UK permitted lead content of petrol was subsequently set for reduction to 0.40 grams per litre of petrol (g/l) by 1981 (from 0.84) (Department of the Environment, 1976b).

From the late 1980s there have been calls from within the public health movement for action on transport. This relates both to issues such as traffic injuries and pollution and also to the environmental and social consequences of transport (Radical Community Medicine, 1989; Transport and Health Study Group, 1991). In England it has been suggested that health authorities should add their voices to those calling for safer cycling and walking environments and for funding for healthier forms of transport (The Health of Londoners Project, 1996). Some public health researchers see a convergence of interest between those concerned with public health, the environment and engineering, with tentative suggestions that issues in common may be enough to overcome barriers of language between these sectors (Fletcher and McMichael, 1997). It has also been suggested that the call to act 'for the public health' could provide the unifying and rallying theme for many interest groups (Jones, 1994).

The calls for action on transport from within public health is an outcome of renewed interest in public health in the 1980s. The Lalonde Report (1974) and the work of McKeown (1976) were catalysts for the re-emergence of public health in the UK and elsewhere (see Chapter 3). They helped raise awareness about the part that social and environmental factors plays as determinants of ill health so that health problems are seen as being influenced by factors beyond as well as under the control of the individual. In this Lalonde and McKeown highlighted the need for consideration of environmental and social as well as bio-medical factors as determinants of health.

There were few specific examples of intersectoral collaboration on transport and health issues beyond the traditional areas of concern such as traffic injuries and pollution by the mid 1990s (Brett, 1995; Davis, 1995). A notable example of collaboration is to be found in England in the growing acceptance of the value of walking and cycling in meeting access needs while providing regular, moderate aerobic physical activity necessary to provide health gains (Davis, 1997). The launch of the National Cycling Strategy in 1996 (Department of Transport, 1996) set targets for

quadrupling the number of journeys made by cycle by 2012 (from a 1996 baseline). In the same year the Department of Health issued the outcome of a consultation on physical activity, *A Strategy Statement on Physical Activity*. This placed the emphasis on physical activities as part of the routine of daily life and specifically identified cycling (and walking) as a means of achieving suggested physical activity levels. The rationale for this *Strategy Statement* was the need to address heart disease and stroke, and the continual rise in overweight and obesity in the population (Department of Health, 1996). This convergence of different policies offered opportunities for inter-sectoral collaboration at both the national and local level in order to achieve some specific transport and health policy objectives.

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Chapter 3

Developing health policy: health on wider agendas

3.1. Introduction

This chapter addresses key debates relating to the emergence and development of Health for All by the Year 2000 policy from the 1970s to the mid 1990s. Section two begins by noting how Health for All was influenced substantively by the ideas of Lalonde and McKeown: that is, that the determinants of health are located largely outside of the health sector, and therefore action needs to be taken in the other areas in order to address these health determinants. Their thinking is reflected in the thirty-eight Health for All targets developed by the World Health Organisation (WHO) in 1985 (WHO, 1985). They include the influence of lifestyles and the environment on health as well as medical care. A concern for equity in health is also made explicit in the targets in order that people may achieve their health potential. The role of inter-sectoral collaboration is recognised since it is a key mechanism for addressing health issues beyond the health sector.

The work of Lalonde and McKeown helped to foster a rekindling of interest in public health from the mid 1970s leading to the development of health promotion as a means by which concerns about a broad range of health determinants could be addressed. Section three examines the origins of health promotion and the debates which followed as to whether new ways of working and structural changes which challenge the *status quo* are required if the Health for All targets are to be achieved.

Section four continues exploring these debates with a discussion about healthy public policies - the need for policies beyond the health sector to take account of the influences they have on health. Healthy public policies imply the re-orientating of health care services towards health promotion, and the section reviews the evidence for this taking place through implementation of Health for All in England, the Netherlands, and Denmark. Much of the literature indicates that

medical services and illness treatment remain the dominant focus of national governments. Some commentators suggest that governments tend to pick and choose which parts of the Health for All policy they wish to take forwards, which precludes challenges to economic and other structural determinants of health. The section explores the focus of much health work.

In 1986 the WHO established the Healthy Cities project as a practical experiment to test out the implementation of Health for All at the local level. Section five addresses Healthy Cities and the many other Health for All projects which developed in its wake. Healthy Cities were expected by WHO to produce lasting improvements to health. The section sets out the debates which have ensued as to whether it is possible for such Healthy City experiments to succeed. Section six poses questions as to whether Healthy Cities are reformist or radical projects. Some commentators have suggested that the very term 'health' may act as a barrier to implementation of Health for All given that health is often associated with ill-health, medical and illness treatment services.

According to WHO, the issue of intersectoral collaboration is critical to the success of Healthy Cities and Health for All projects. Section 7 identifies various definitions in the literature used to describe inter-sectoral collaboration. Experience of attempts to pursue collaboration are reviewed and the key barriers encountered are discussed. The identification of entrenched professional boundaries leads to claims that conflict is necessary in order to overcome such barriers. Some commentators have suggested that skilled negotiators and 'entrepreneurs of power' (Power, 1973), may have an important role to play through their ability to identify critical pathways through decision-making structures.

As it has been suggested that the term health can be problematic, the idea has been posed that quality of life may have more practical value in Health for All work. The final section (eight) explores how quality of life has been defined within environmental and health literatures. It finds

some commonalities in these accounts and identifies ways in which both have developed to be more inclusive. These include considering public and patient perspectives since it is people's perception of their own well-being that ultimately defines the quality of their lives.

3.2. Health for All - a utopian idea or achievable ambition?

3.2.1 Health for All by the year 2000

The Health for All initiative began in 1977 when member states of WHO agreed a resolution at the World Health Assembly that:

“the main social target of governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.” (World Health Assembly, 1977)

The following year, the WHO called a joint international conference on primary health care in Alma Ata, USSR. The resulting declaration defined primary health care more precisely than previously and stressed that it was the key to attaining Health for All (Whitehead, 1993). The Declaration of Alma Ata emphasised the importance of equity, economic and social development, of participation by the people in the process of improving health, and the key role of primary care (WHO, 1978). During the early 1980s, the World Health Assembly resolution and the Declaration of Alma Ata were formulated into global and regional strategies for Health for All by the year 2000.

3.2.2 Targets for Health for All

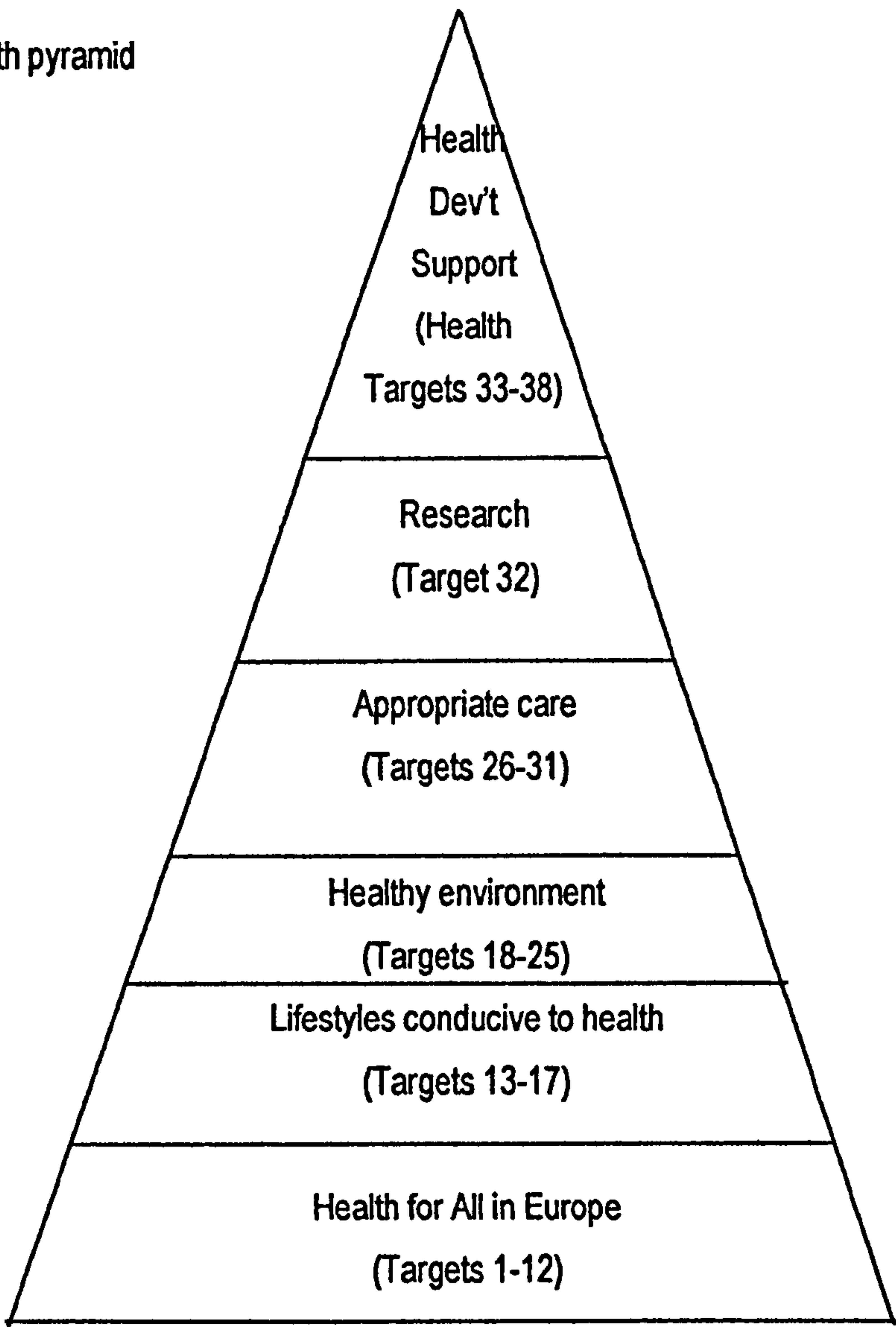
WHO promoted a common approach to health policy in Europe by developing a series of targets for improved health status which reflected the Health for All strategy (Nutbeam and Wise, 1996). The thirty-eight targets were designed to be a framework within which the various countries in the European Region could measure progress towards the attainment of Health for All (WHO, 1985).

The targets cover a broad range of issues, and are divided into six themes. These are equity, health promotion, community participation, multi-sectoral cooperation, primary health care, and international cooperation. Targets 1 and 2 are concerned with the basic policy orientation of the European strategy towards greater equity and wider achievement of health potential. Targets 3-12 are largely focused on reducing death and illness from specific diseases and conditions, mainly through medical surveillance and interventions. Some are concerned with particular population groups such as children and the elderly. Targets 13-17 relate to the promotion of healthy lifestyles, by enhancing the knowledge, motivation and skills of people to acquire and maintain their own health. Targets 18-25 refer to healthy environments and to reduce the risk of and to environmental hazards, such as water and air pollution. Primary health care is addressed in targets 26-31, including access to and quality of health care. Research is identified by Target 32 in order to support Health for All development. Targets 33-38 address health development support, stipulating that all Member States ensure that their health policies and strategies are in line with Health for All principles, and that planning, resource allocation and training are geared towards the achievement of Health for All policies. The Health for All targets were subsequently updated in 1991, drawing on the experience gained in the intervening years in the implementation of the European Health for All policy and its thirty-eight targets (pages xii-xvii). In particular, Target 2 was amended from 'Developing health potential' to 'Health and quality of life' in order to reflect the importance of quality of life as well as health (WHO, 1991).

Rathwell has suggested a 'health pyramid' (Figure 3.1) as a way of setting out these themes and targets, with the achievement of each set of themes being in ascending order, so that the more traditional health sector area of disease treatment is addressed first (Rathwell, 1992a). This is not so different in perspective to the way that the WHO set them out. What is important to note, however, is that the targets higher up in the pyramid are further 'upstream' than those lower down or 'downstream' which are focused on medical interventions (McKinlay, 1993). Addressing issues

upstream, for example, air pollution, can reduce the burden downstream by tackling at source the health hazard, such as by controlling emissions from factories or motor vehicles, negating the need for medical interventions.

Figure 3.1 Health pyramid



Source: Rathwell, 1992a

3.2.3 New perspectives on health

Much of the inspiration for Health for All can be traced to the Lalonde Report in 1974. This report, *A New Perspective on the Health of Canadians* (Lalonde, 1974), set the agenda for a new era of preventive medicine (Hancock and Duhi, 1986; Bunton and McDonald, 1992). Lalonde identified that the dominance of the medical perspective or 'gaze' had obscured the fact that the

origins of much ill health and disease derived from activities beyond the health sector and so required serious attention to be directed to the wider determinants of health. Lalonde introduced the idea that all causes of health and disease could be attributed to four discrete and distinct elements (Figure 3.2): inadequacies in current health care provision; lifestyle and behavioural factors; environmental pollution; and bio-physical characteristics (Macdonald and Bunton, 1992). A key element of the Lalonde Report was that it was the first time a major industrialised country endorsed the analysis of epidemiologists such as Thomas McKeown (O’Neil, 1993).

Figure 3.2 The health field

Human biology	Lifestyle
Environment	Health care organisation

Source: Lalonde, 1974

McKeown (1976) argued that most of the improvements in mortality in England and Wales between 1840 and 1970 had occurred before the availability of effective treatments. Diseases such as measles, whooping cough and tuberculosis were declining significantly before the introduction of immunisation and effective medical interventions. McKeown claimed that the main contributions to improved health came, in order of importance, from reductions in the size of families, increases in the food supply, and a healthier physical environment. These, he identified, were the outcomes of behavioural and environmental changes. Specific preventive and therapeutic measures had also played an important although lesser role. From this he concluded that orthodox medicine was providing an inappropriate response to health needs, largely reactive and demanding of conclusive evidence of disease (McKeown, 1976). It has been claimed that the

impact of the McKeown analysis together with the diminishing returns associated with medical treatments played an important part in renewed interest in preventive treatment, and the belief that it could be possible to plan for health rather than just planning to treat disease (Ashton, 1989).

3.3 Health promotion - reflecting the values of Health for All?

With the work of Lalonde and McKeown as reference points, Health for All has fostered a strong resurgence of interest in public health, in particular refocusing attention on social and economic determinants of health, and their unequal impact on the health of populations. The term 'health promotion' emerged in the 1980s, although its foundations were laid in the 1970s. Building on the initiatives such as the Declaration of Alma Ata and the Health for All targets, the Ottawa Charter defined health promotion as:

"the process of enabling people to increase control over, and to improve, their health... Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being." (WHO, 1986)

Health promotion has been viewed as distinct from health education where this has been identified with lifestyle approaches, focusing on individual behavioural changes, and a tendency towards victim blaming and disempowerment (Yeo, 1993). Tones et al (1990) argues that health promotion differs from health education in that the former is not considered to be the preserve of the medical services and must therefore be orientated differently (Tones et al, 1990). However, health promotion has also been viewed as a vaguely conceived umbrella term, very often used in relation to traditional health research and programmes (McQueen, 1994). This has raised the

question of whether health promotion is more rhetoric from health educationalists than substantive change (Research Unit in Health and Behaviour Change, 1989).

Those that see health promotion as offering a radically new concept of health identify particularly with the need to address policy areas beyond the health sector, and view inter-sectoral collaboration as a mechanism through which the Health for All targets can be achieved. This requires new ways of working, not least because it necessitates structural changes beyond the influence of individuals and the health sector (Tones et al, 1990). In this aspect particularly, health promotion can be seen as challenging the status quo and government policies (MacDonald, 1996).

3.4. Health care versus healthy public policy

3.4.1 Healthy public policies

As noted above, the breadth of policy areas addressed by Health for All acknowledges that health work 'must attend to the policy sectors and organisational actors affecting the conditions and conduct that create health' (Milio, 1981). This has been termed 'healthy public policy' by Milio. Target 13 of Health for All is focused on healthy public policy and declares that:

"By the year 2000, all Member States should have developed, and be implementing, intersectoral policies for the promotion of healthy lifestyles, with systems ensuring public participation in policy-making and implementation." (WHO, 1991)

Much of the health sector from which Health for All originates and from which it needs support in order to be carried forward is, however, oriented around a narrow bio-medical model of health. This includes, it is suggested, the dominant values within much of health education and promotion work. These are individualistic and elitist (Rodmell and Watt, 1986), resulting in a

focus on lifestyle issues which has led to claims of victim blaming (Crawford, 1977; McKinlay, 1993).

Definitions of healthy public policy incorporate very broad visions of health, crossing traditional disciplinary, organisational, and governmental boundaries. They recognise the need to manipulate the social policy environment in order to create a healthy society, implicitly acknowledging that the social environment is an important determinant of health. In the Adelaide Charter, the WHO defined healthy public policy as being:

“characterised by an explicit concern for health and equity in all areas of policy and by accountability for health impact.” (WHO, 1988)

From a public health perspective this entails addressing policies in sectors other than health. As has been noted:

“it is only if public health practitioners can influence or deploy the resources of those in other sectors that truly effective activities can be developed.” (Steensberg, 1997, p. 312)

3.4.2 Reorienting health care towards Health for All?

Many European governments have claimed their commitment to reorientate health care services towards health promotion (Wall, 1996). Countries have, however, tended to be selective in what they choose to address in relation to the Health for All targets, often focusing largely on medical interventions and illness treatment services.

“The health care services in most countries carry on with business as usual, in the midst of increasing pressure for cost containment.” (Nutbeam and Wise, 1996 p. 219)

In England, despite the adoption of the thirty-eight targets, policy and practice continued to reflect the concerns of the NHS. While the government was theoretically committed to the principles of Health for All, it has been noted that national policy and resultant structures oriented around medical services mean that Health for All initiatives have been hard to finance from 'mainstream' resources (Jacobson, 1990).

Research undertaken by the Institute of Health Service Management in 1990 sustains a view that support of Health for All initiatives by NHS Managers has been highly selective and 'has never been at the top of most general manager's lists of priorities' (Diskin, 1990). Further studies by the Nuffield Institute confirm this interpretation, concluding that the choice of Health for All issues was strictly limited and NHS initiatives rested very largely with Public Health departments (Rathwell, 1991). As Hunter has noted, treatment of the sick is the central function of the NHS.

"Despite the rhetoric and good intentions stretching back decades, the NHS is not a health service. Its whole ethos and bias is towards caring for the sick." (Hunter, 1995 p. 1589)

The 1992 White Paper, *The Health of the Nation*, was, according to Goumans and Springett (1997), a belated and weak response to Health for All. It identified five key areas, setting goals and targets for each, and strategies for achieving them. These were: coronary heart disease and stroke; cancers; mental illness; HIV/AIDS and sexual health; accidents. All of these key areas relate directly to the Health for All targets concerned specifically with disease and ill health (Rathwell, 1992a). Little mention was made of the importance of wider determinants of health, although *The Health of the Nation* did place emphasis on inter-sectoral collaboration, termed 'healthy alliances', as a key vehicle through which goals could be met. A Ministerial Cabinet Committee was established to:

“oversee implementation, monitoring and development of the English strategy; and to be responsible for ensuring proper coordination of UK-wide issues affecting health.”
(Department of Health, 1992 p. 22)

According to Delaney (1996), terms such as ‘healthy alliance’ simply provide Health for All with ‘soundbite’ status, suitable for use in documents such as the Health of the Nation White Paper. A review of the success of the White Paper’s policies found that collaboration in order to implement aspects of the government policy was largely a failure because it lacked ownership by all sectors. *The Health of the Nation* policy was perceived primarily as part of the health service agenda and so was not taken up by local government (Fulop et al, 1998). Delaney also reports that there has been retrenchment in other policy sectors, often due to cost containment requirements, leading to a narrow interpretation of ‘statutory function’ (Delaney, 1994a) which excludes wider issues such as public health.

In the Netherlands, a similar scenario has been described (de Leeuw and Polman 1995), where adoption by the national government of the Health for All targets did not lead to action to progress the majority of those focused beyond the health sector. During its development, Dutch Health for All policy was undermined in two respects, it is claimed. Firstly, Nota 2000, the Dutch governmental response to Health for All, in 1986, was, according to de Leeuw and Polman, downplayed in its drafting because it was perceived as a threat to other departments. This was because it would require them to change some policies and practices to reflect Health for All. Secondly, the Dekker Report published in 1987, which advocated a free market-oriented approach to health care, further undermined the status of Nota 2000. While Nota 2000 sought coordinated interventions across the public policy fields the Dekker Report called for a laissez-faire approach (W. Dekker, Managing Director of Phillips) (de Leeuw and Polman, 1995). The acceptance by the Dutch government of the approach contained in the Dekker Report and its recommendations reflected a concern within most western countries in the 1980s for cost

containment in the health sector. Cost containment tends to involve reducing the number of, and focusing on, core activities, so this is an obstacle to Health for All policy oriented beyond the health sector (Dekker and Saan, 1990; Baum, 1990).

Dekker has remarked that the focus of Health for All during the 1980s was on medical services. This, he believes, appears to have marginalised Health for All not only in the Netherlands and England, but also in other European countries. Health For All had not, therefore, achieved its aim of broadening health policy beyond the treatment of illness.

“For in those countries the health policy agenda contained items such as cost containment, planning of services, negotiation with care provider’ organisations etc., in short, ‘traditional’ items.” (Dekker, E. 1994 p. 285)

In Denmark, by way of contrast, there has been less emphasis on the role of the free market and Health for All policy has not been so marginalised as in other European countries. Denmark’s, welfare policy is seen as an integral element of society, and concepts like security and promoting good living conditions are highly valued (Swedish National Board of Health, 1993). During the late 1980s and early 1990s, the Danish Ministry of Health was supportive of health promotion and Health for All (see Chapter 6). It prepared its own health promotion programme in 1989, the first of its kind in Denmark, in response to the WHO Health for All strategy (City of Copenhagen, 1994).

3.4.3 Health for All: radical in rhetoric but politically weak?

Implementation of all the Health for All targets requires some tangible support from national governments. WHO cannot compel Member States to adopt and implement a Health for All policy; it can only cajole. Rathwell suspects that governments will continue to ‘only highlight those aspects which put them in a good light’ (Rathwell, 1992b p. 545). Similarly, there is also the issue

of whether there is enough support within the health professions for Health For All (Ashton, 1991; Goldstein, 1997), and whether governments and health sectors can work effectively to engage with those in other policy areas.

One significant barrier to developing a comprehensive Health for All agenda in many European countries is the failure of governments to acknowledge the role played by socio-environmental conditions in determining health. Socio-environmental determinants forms a significant element of the Health for All strategy. As noted earlier, expenditure continues to be focused on medical services and the treatment of ill-health rather than health promotion and sickness prevention (Rathwell, 1992b; Goumans and Springett, 1997). This has led to pleas for 'upstream thinking' in order to address the structural issues (McKinlay, 1974, 1993) over which individuals may have little control, such as poor housing, access to affordable healthy diets, and traffic danger as a barrier to walking and cycling.

The narrow focus of much health work has led to predictions that the Health for All targets would not be achieved by 2000. Even at the outset, the timescale for achievement of Health for All was criticised as unreal, being based on assumptions that economic development would automatically lead to improvements in public health (Strong, 1986). Baum and Saunders, have proposed that a redistribution of income and wealth within and between countries is required if Health for All is ever to become a reality.

"We argue that rather than reducing the health promoter's vision in order to promote health equitably, we need to broaden the questions asked and accept that health is about change and processes, not about static goals and targets." (Baum and Saunders, 1995 p. 156)

This reflects Farrant's view (1991), that a fundamental deficit in the Health for All philosophy is the implicit assumption that equity in health can be attained in the absence of a radical

restructuring of society. She provides the example of the Health for All focus on addressing inequalities and the emphasis on empowerment of disadvantaged groups but claims that the 'the public' and 'the community' are frequently homogenised as a whole:

"with little encouragement to systematically analyse power relations within and between communities... [and] it is rarely acknowledged that participation involves conflict and confrontation as well as consensus and cooperation and, to be effective, would require a fundamental shift in the distribution of power." (Farrant, 1991 p. 431)

Farrant also cites the WHO which has reported that countries which have started a process of national change by a political process have a clear advantage. WHO states that the 'forces that influence such change reside beyond the realm of WHO's work', thereby acknowledging that it is not within their power to engage in politics. Farrant believes this to be an atheoretical pragmatism which serves both to obscure entrenched political barriers to change and to allow the 'misappropriation of the Health for All strategy by those with a vested interest in the status quo' (Farrant, 1991 p. 429). Vested interests seek to maintain the dominant values of health care and marginalise broader approaches to health policy. This is an issue also addressed by other commentators (de Leeuw, 1993; Baum and Saunders, 1995; Coombes, 1997). Strong argues that WHO's failure to address political issues, notably the state and the medical profession, is simply because the organisation is too dependent upon them (Strong, 1986).

3.5 Healthy cities - putting Health for All into practice

3.5.1 Healthy Cities: A tool for implementing Health for All

Healthy Cities have been 'field laboratories' for testing Health for All initiatives at the local level and give important feedback to WHO and member states that can be used to update and refine the Health for All strategy (Tsouros, 1995 p. 133). Established by the WHO (Europe), Healthy Cities has a broad commitment to an environmental and social model of health rather than one

which places action for health solely within the bio-medical model. In recognition of this, local government has been identified as the central organisational body because it is best placed, in WHO's analysis, to be a focal point for public participation in health (Tsouros and Draper, 1993). In this way it is envisaged that a key objective of the Healthy Cities project, to make health a major public policy issue, can be achieved.

The Healthy Cities project has, perhaps, been the most tangible example of the 'new public health movement' (Ashton and Seymour, 1988). McKeown's work provides a constant reference point for the new public health, which recognises the influence of environmental changes, and personal prevention measures with appropriate therapeutic interventions (Ashton and Ubido, 1991). It recognises that the determinants of health are multi-factoral, including both physical and social environmental determinants from the individual level to that of culture and the global ecosystem. That is, beyond basic human needs for food, shelter, clean water, a safe environment and peace, there are also a range of other factors such as social networks, self-esteem, power and control over events in one's life (Hancock, 1993).

The designated project cities were intended to be models from which other cities could learn, both about successful ways of working, and equally importantly, about the obstacles and possible solutions to enable collaborative action. Other cities were actively encouraged during the first five years of Healthy Cities to undertake initiatives and many have initiated their own programmes based upon the same or similar principles drawn from WHO's Health for All by the Year 2000 strategy.

By the early 1990s there were over 30 designated cities across both West and Eastern Europe, plus over 370 cities worldwide in national and international networks. Indeed, it has been suggested by WHO's Healthy Cities Coordinator, that it is a project that has become a movement (WHO, 1990). Most of the designated Healthy Cities have been municipal authority lead (Curtice,

1993). This is partly due to the fact that in most of the participating European countries there is no state health service separate from local municipalities. Some projects, for example, are located within municipal health departments while others are in Chief Executive's offices. In this research, one of the case study cities, Copenhagen was a WHO designated Healthy City, requiring political commitment and resources for the project from the municipal authority. The other two cities Groningen and Sheffield were not WHO designated but nonetheless Health for All projects were established under the auspices of the municipal and health authorities.

3.5.2 Short term projects or long term policy change?

While WHO acknowledged that project cities by themselves would not achieve long-term shifts in the orientation of public policies they established a set of criteria to which any applicant city to the project needs to show commitment. These were:

- political will to develop a health plan and to devote resources to the project;
- visibility of the project;
- to change the organisational culture of city governments because cross-sectoral health policies are almost impossible to implement effectively within a fragmented bureaucratic structure where there is no established means to enforce public accountability;
- to show some short-term gains.

As part of the process, project cities need to set up or work with a small number of well-defined programmes or projects which are clearly innovative and demonstrate the value of new approaches to developing health in cities (Curtice, 1993).

The criteria demonstrate the expectation that Healthy Cities will make some lasting impacts on their localities. Political commitment, a willingness to undertake fundamental changes in municipal institutions, and a commitment to develop positive and empowering relationships with their communities are seen as central. Through work in small geographical areas the projects

themselves can create oases of health in cities but only policies can distribute and equalise their benefits across cities (WHO, 1994).

3.6 Healthy Cities: A reformist or radical project?

Critiques of Healthy Cities are not limited to identifying the need to extend isolated projects which involve only small sections of city populations. As with charges that Health for All cannot be achieved without radical changes, questions have been raised about whether Healthy Cities are possible without challenging and changing the structures which create 'unhealthy' cities. Baum specifically questions whether the new public health can deliver healthy cities since it assumes cooperation for the common good when, in fact, vested interests and conflict seems the more logical outcome (Baum, 1990). She cites the likelihood of local politicians and public servants being happy to support initiatives that bring about minor changes but having difficulty with an initiative which seeks to address the source of a health problem when it might challenge a local employment policy and the need to cooperate with business (Baum, 1993).

Kelly et al (1993) have argued that there is a more fundamental problem for the Healthy Cities movement, which is that conventional scientific research and the Healthy Cities concept belong to two different worlds. They identify these fundamental differences with modernity and post-modernity.

"Modernity is the world of conventional scientific research and rational administration applied to problems, physical or social. Post-modernity is a world of aesthetics, of the deconstruction of conventional social arrangements, and the experimentation in cultural, artistic and life forms." (Kelly et al 1993 p. 159)

Unlike the modernist view, which asserts that there is an answer to a question which it is the task of the scientist to reveal, the post-modern view is relativist, asserting that 'all there is' is an array

of diverse and competing stories: that alternative and mutually exclusive explanations co-exist. In the post-modern perspective there is a plurality of beliefs and behaviours with conflict between them being an inescapable part of the social condition (Open University, 1993). Kelly et al claim that the modernist view is system-based, whether or not a social or medical model of health is applied, because both are built upon the assumption that an underlying system is open to scientific explanation and investigation. Healthy Cities and Health for All, however, place emphasis on *positive health*, not amenable to conventional scientific investigation, belonging as they do, to quite separate ways of conceiving health than that associated with disease and medicine. 'Positive health is a quality of individuals and social groups that is self-defined, not externally imposed' (p. 162), and the focus for Healthy Cities should be on the origins of health rather than disease (Kelly et al, 1993).

Others view the Healthy Cities project with greater confidence, seeing radical changes beginning to occur in a few locations (Goumans and Springett, 1997). They tend to place more emphasis on Healthy Cities as a long term project, involving learning new ways of working (Costongs and Springett, 1997). Evidence from cities in England and the Netherlands which adopted the Healthy Cities idea suggests that in order to progress the health agenda, health promoters pursued a pragmatic strategy by associating health with those policy issues which were already high on the citys' political agenda. The researchers found no evidence, however, that this strategy had been effective. They did note that a pragmatic approach may be needed to avoid too much emphasis on the word 'health' because health may not be viewed by local decision makers as a policy driver (Goumans and Springett, 1997). This conclusion is reflected in research for WHO reviewing the progress of the Healthy Cities project, which has also reported that health may not be the most appropriate term to use when seeking to develop inter-sectoral initiatives:

“the concept of health in itself does not have an intrinsic value for policy makers. Successful Healthy Cities have been able to translate health into a value closely related to urban planning, local economy, ecology, etc...” (de Leeuw, 1998 p. 4)

Some commentators addressing Healthy Cities and Health for All have discussed project goals in terms of health or quality of life, reflecting the 1991 revised Target 2 of Health for All (Health and quality of life). Health and quality of life has sometimes proved useful in motivating disparate groups into coalitions to achieve improvements in living conditions (O'Neil et al, 1997).

3.7 Inter-sectoral collaboration: theory verses practice

3.7.1 Defining inter-sectoral collaboration

Inter-sectoral collaboration is central to current conceptualisations of health promotion and Health for All (WHO, 1984; de Leeuw, 1989; Nutbeam, 1994). Within the health sector, the call for collaboration has come largely from within public health and health promotion. Inter-sectoral collaboration has been defined as actions taken outside the health sector, generally in partnership with the health sector, with the explicit intention of improving individual or community health (Nutbeam, 1994). The ‘health sector’ in this case is broadly defined to include health bureaucracies, individual health professionals and their representative bodies, and non-government and consumer health groups.

Inter-sectoral collaboration is a phrase which reflects the general acceptance, not just within health promotion but also beyond, that few problems with a social dimension can be solved by organisations and individuals working alone (Hudson, 1989; Hanf and O'Toole, 1992). Huxham notes that being effective means understanding not only how to manage what happens within an organisation, but also how to manage inter-organisational interactions (Huxham, 1993). This is reflected by Sindall when he notes that, according to many management writers:

‘networks, processes and strategic alliances are now the defining characteristics of ‘modern’ organisational relations’. (Sindall, 1997, p. 5)

Within the domain of inter-sectoral collaboration there is also the issue of ‘inter-departmental’ and ‘intra-departmental’ collaboration. Collaboration internally within an organisation, between and within departments, may be equally as important as external collaboration, and it may be beset by barriers similar to those experienced through inter-sectoral collaborative efforts. In the early 1990s, for example, the Audit Commission in England, reported on widespread fragmentation between local government services and duplication of effort (Audit Commission, 1994). It noted the lack of internal communication and mutual awareness among senior managers across local government departments as a significant barrier.

3.7.2 Debates about inter-sectoral collaboration

Joint working between organisations and individuals in different sectors to promote health is at the core of inter-sectoral collaboration. It has been described in many ways within health promotion. The phrase inter-sectoral appears to be interchangeable in the literature with that of multi-sectoral. Bunton (1992), for example, notes that healthy public policy refers to multi-sectoral and collaborative processes. This phrase multi-sectoral is likewise used by others such as Speller and Funnell (1994) in their work for the Health Education Authority in England to support the development of ‘healthy alliances’. As noted above, the concept of healthy alliances was itself identified by *The Health of the Nation* White Paper (Department of Health, 1992) as an arrangement for joint working, and again implies inter-sectoral or inter-disciplinary working. Inter-sectoral collaboration has also been expressed and defined in other terms. These include inter-sectoral cooperation and coordination, coalitions, social movements or formal inter-organisational arrangements (Costongs and Springett, 1997). Costongs and Springett note that whatever the term, there is always a degree of joint working and networking underlying collaboration.

Grey (1985) states that collaboration is the result of mutual understanding between stake holders of the value of joint work to achieve common goals and overcome problems that may be encountered:

"by collaboration we mean: the pooling of appreciations or tangible resources... by two or more stake holders, to solve a set of problems which neither can solve individually." (Grey, 1985 p. 912)

Costongs and Springett (1997) argue that it can be more than this, as collaboration creates opportunities to exchange and share the beliefs and values of different sectors and organisations. Through this, they note, inter-sectoral collaboration creates 'arenas for dialogue' in the quest to improve health. Similarly, Hudson (1995) has noted that effective collaboration requires the development of a shared sense of purpose. It also requires trust and openness, a commitment to working as partners, an understanding of the other's structures, duties, responsibilities and decision-making machinery, and a willingness to be accountable to the other partners for the undertaking of agreed tasks. Webb's (1991) review of the literature highlights barriers to what he terms coordination, particularly in relation to the issue of trust. He notes that everyday experience suggests that coordination is easier within than between organisations. Webb differentiates between coordination and collaboration and sees the main differences as being that collaborative action involves long-term commitment and consensus on goals and objectives are clear.

3.7.3 Collaboration: structural and professional barriers

Hudson has made a particular study of collaboration between English health and social services (Hudson, 1987; 1989; 1990; 1995) and described many barriers, such as cultural difference in ways of working, and lack of trust. Such barriers are also identified in the wider literature addressing inter-sectoral collaboration which likewise notes that collaboration is fraught with difficulties. An indication of the degree of difficulty likely to be encountered when developing

collaborative initiatives is that even between policy areas which recognise their close links, such as between health and social services, the barriers to collaboration are many (Booth, 1981; Blackman, 1995). Some researchers have gone as far as describing the problems of collaboration in this area as a 'Berlin Wall' (Hiscock and Pearson, 1999). This does not augur well for areas of public policy where the need for collaboration is less well understood. A review of the literature on inter-sectoral collaboration for action on health by O'Neil et al (1997) concluded that:

"what the authors generally concede, in fact, is that this type of work fails more often than it succeeds." (O'Neil et al, 1997 p. 80)

Barriers to collaboration include vested interests, structural complexity, and divergent professional and organisational cultures. Any of these can lead to mistrust. Moreover, organisations are characterised by multiple and often conflicting values and priorities requiring those working inter-sectorally and sharing the same vision and values to compete for political favour and scarce resources 'back at base' (Delaney, 1994b).

Degeling highlights the problems of professional cultures and the way professions organise and operate. These tend to reinforce barriers through the defining of boundaries that separate them from other sectors so framing what is to be excluded (Degeling, 1995). According to Degeling, sectors are often characterised by specialised discourses of knowledge and expertise in seeking their legitimisation and maintenance. Each sector has well-established functions and its primary interest is normally to maintain and develop these.

Some writers focus on lack of awareness and ignorance rather than conflict. Hudson, for example, has noted that 'positive mutual awareness' is not a feature in health and welfare in Britain (Hudson, 1989) and that different values are a root cause of this. Nocon (1989) suggests

that there can also be considerable ignorance about potential collaborators. He identified six forms of ignorance:

- structural ignorance about the way that other organisations work;
- ideological ignorance about underlying organisational philosophies;
- ignorance of other professional cultures;
- procedural ignorance about implicit and explicit organisational goals;
- personal ignorance;
- positional ignorance of how to achieve desired ends.

A seventh form of ignorance may also be the pervasive myth that good health is the result of medical and hospital services. Some professionals and other non-health groupings may perceive health as largely the domain of health services from which health initiatives originate and should be controlled. Goldstein adds that the inter-connection between health and other policies may be unclear even among some within the health sector because of an inability to conceptualise health problems in terms of their social and environmental causes (Goldstein, 1997).

Addressing this narrow perspective of health has been a starting point for many Healthy Cities and Health for All initiatives. For example, in Camden, London, as part of a consciousness raising exercise at the beginning of the Camden Healthy Cities project in 1989, local government staff were invited to a briefing on the Health for All Strategy to discuss the ways in which the Council plays an important role in health promotion. Key actors in Camden Healthy Cities have described the Council as a 'health authority' as one way of highlighting its ability to contribute to health:

"the Council is a health authority and the services they provide can have an even greater impact on the health of people who live and work in the borough than the medical services provided by the NHS." (Pike, O'Keefe, and Pike, 1990, p. 19).

Research in England on healthy alliances has suggested a range of issues which need to be addressed if collaboration is to be effective (London Research Centre. 1993). These are the need to/for:

- Establish a formal collaborative structure;
- Hold regular meetings with appropriately sized groups in order to establish relationships;
- Ensure stability and consistency;
- Mandated authority;
- Informal networks;
- Organisational commitment beyond the symbolic;
- Resources;
- Coordinator/support staff.

Such findings have variously been reported by others (eg Delaney, 1994a; Hanf and O'Toole, 1992). Recent evidence mirrors Delaney's findings that organisational changes outside the health sector have led to agencies focusing on their 'core business'. Hiscock and Pearson (1999) report that since the mid 1990s changes within the health sector have reduced the likelihood of collaboration with outside agencies, such as social services, because of the need to focus on core functions.

3.7.4 Conflict rather than collaboration?

Some commentators focus on vested interests, as noted above, and the problems this causes attempts at collaboration. Baum (1990, 1993), addresses professional boundaries relating to the medical professions, the dominance of medicine in the health sector, and its implications for Healthy Cities projects. She sees the medical professions' reluctance to share power with others as a major problem for Healthy Cities in the quest for healthy public policies. She therefore views conflict as the more likely outcome of attempts at collaboration with the health sector. Conflict, Baum believes, is indeed necessary to achieve changes in an entrenched system. In similar vein,

Degeling (1995) views the rhetoric of inter-sectoralism as lacking substance because of in-built biases within 'sectors'. Lack of inter-sectoral action is not, therefore, due to faults or errors which can be overcome by 'better organisation' and 'better communication'.

Moran (1991), discussing English health policy, sees the issue from a more ideological perspective. In Moran's view, the health service re-organisations of the 1980s led to fragmentation of responsibility and lack of guidance on joint planning. They signalled the government's judgement that collaborative planning procedures were unacceptable in principle and were to be replaced by market forces. This results in rhetoric but no action (Moran 1991). Other policy analysts have likewise noted the tendency for symbolic policy to become a substitute for action (Fudge and Barrett, 1981).

3.7.5 The role of reticulists: sidestepping conflict?

A theme to emerge in the literature has been the role of 'reticulists'. In order to establish and maintain links between organisations, it is argued, intermediaries may be required to remove barriers to collaboration and ensure relationships can work optimally (Hanf and O'Toole, 1992). A reticulist is someone who possesses skills in creating, servicing and manipulating communication networks, and is astute at identifying where in an organisation a decision in which she/he is interested would be made (Power, 1973). Power proposed the neologism 'reticulism' and the role of the reticulist. It has been developed by a number of authors since and applied to the development of inter-sectoral collaboration (Friend, Power and Yewlett, 1974; Degeling, 1995; Hudson, 1995). Power describes the reticulist as a power craftsman, and a specialist in bilateral negotiations, in hard bargaining with other political actors, and also as an entrepreneur of power. Power sees that reticulists are sceptical of all proposals to attain coordination through group consensus, the approach applied in Healthy Cities and Health for All projects. He also views reticulists as being wary of those with particular areas of expertise in public policy because of the

rigidity it builds into organisations. Drawing on Power's work, among others, Degeling suggests that reticulists have a range of skills necessary in order to:

“understand where coupling, inter-dependencies and fissures are likely to occur and are skilled at identifying the strategic points in the existing web of relationships from which entry can be gained and leverage can be exercised.” (Degeling, 1995 p. 297)

Likewise, Gray (1985) notes the importance of ‘skilled conveners’ who appreciate the potential for mutual exchange and envision a mission which can be fulfilled through joint participation. Reticulist skills are associated too with boundary crossing and strategic thinking (Friend, Power and Yewlett, 1974). Hudson (1995) notes that because of their ability to identify the key resource holders and fellow reticulists in their own and other agencies, reticulists may have an important role to perform.

3.8 Defining quality of life: Health and environmental perspectives

3.8.1 Quality of life: more than health?

If use of the term health can be problematic because of its association with ill health both outside and also within the health sector (Baum, 1995; Goldstein, 1997), Healthy Cities and Health for All projects may have to situate their work under project labels which are more acceptable to both politicians and officials responsible for policy areas beyond health. As noted earlier, Target 2 of the WHO Targets for Health for All was amended in 1991 to ‘Health and quality of life’ in order to reflect the importance of quality of life as well as health potential. Target 2 can be achieved, it is suggested by the WHO, if:

- monitoring of health potential and quality of life is strengthened;
- active participation in community life is encouraged;
- access to the prerequisites for health, especially education, is improved;
- healthy lifestyles based on effective coping skills become widely accepted;

- health and environmental aspects of living and working are improved and social networks strengthened;
- greater emphasis is placed on the quality of life in providing primary, secondary and tertiary care (WHO, 1991).

This interpretation of health and quality of life acknowledges that health is just one component of quality of life, albeit an important component. It reflects the WHO's view, stated in the Ottawa Charter, that health should be seen 'as a *resource* for everyday life, not merely the object of living' [my emphasis] (WHO, 1986). Quality of life is important to the everyday experiences of people whereas, by contrast, health, as understood to mean disease, is absent for much of peoples' lives. While many are concerned with their health it is not the only factor that is important to them. This is reflected in UK surveys concerning the public's views about quality of life in which crime stands out as the most important issue (Department of Transport, 1989; Royal Automobile Club, 1998). UK researchers involved with environmental conceptualisations of quality of life have reported that

"The average person's perception of quality of life is dominated by 'life' itself. That is to say, they want to live in places with minimal violent crime and with the best possible health services." (Rogerson, Findlay, and Morris, 1988, p. 1)

3.8.2 Environmental and health accounts of quality of life

Two conceptualisations of quality of life are prominent in the literature: one focused on environmental quality and the other on physical and mental functioning and well being. Quality of life as a measure of satisfaction has been widely adopted in the social sciences, most notably in psychology and sociology, in order to provide a subjective evaluation of the consumption of environmental living conditions. Much of the focus of this work is on urban living.

In medical and health care services quality of life has been conceptualised in terms of individuals' physical and mental functioning and well being. Ruta and Garratt note that a search of the medical literature between 1989 and 1993 under the search term 'Quality of Life' will generate around 1500 published papers (Ruta and Garratt, 1994). The dominant position of medical services and the treatment of illness within health care services is reflected in this approach to quality of life with much of the discussion centred on the physical functioning of the body. Debates about quality of life as part of measuring the outcomes of medical care have arisen in part from the challenge to previous indicators which have predominantly expressed health in terms of reductions in mortality and/or morbidity (Rogerson, 1995). Critically, it has been claimed that quality of life assessments encapsulate a desire to give clinical medicine a more holistic face by attempting to find ways of incorporating aspects which are immeasurable alongside scores and numbers (Fallowfield, 1990). As with other approaches to quality of life, medical interpretations raise important questions about how quality of life can be evaluated and by whom. Bowling has critically reviewed a broad range of quality of life measures which attempt to take account of how the patient feels, not just physical functioning. She notes that few self-rating scales exist despite the determining role that the potential patient has in decisions about the seeking of care, acceptance of treatment and in considering themselves to be well and recovered (Bowling, 1991).

Within environmental accounts there is a consensus that there are two fundamental processes operating: those which relate to an internal psychological mechanism producing a sense of satisfaction or gratification with life, and those external conditions which trigger the internal mechanism (Grayson and Young, 1994). The former relates to what have been described as the social attributes, such as the sense of community and neighbourhood and the latter to the physical attributes of the environment in which people live (Rogerson in Grayson and Young, 1994) such as housing quality, traffic environment, employment opportunity and the risk of crime. There is also the view that quality of life must embody notions of power and empowerment - the

belief that undesirable conditions can be transformed by personal and political action (Young and Mills, 1983). Similarly, in health care, an approach, devised from reviewing a range of quality of life indicators used in social gerontology, has been suggested by Hughes (Hughes, 1990). She makes the distinction between the conditions of life and the experience of life. Conditions of life such as housing or income are considered to be objective whereas experiences of life such as life satisfaction and positive self-image are more subjective.

3.8.3 Similarities between quality of life accounts

There are some similarities between environmental and health accounts in the way in which quality of life has been conceptualised. Health-related quality of life indicators, such as mortality rates and health service use data, aim to provide 'objective' measures of the healthiness of individuals, and in most respects mirror the objective social indicators of environmental quality of life studies (Rogerson, 1995). Both accounts have sought to develop approaches to help prioritise various factors through which quality of life is generated and to place value on qualitative as well as quantitative factors. In both accounts, quality of life has become important as a concept not least because it denotes a recognition of differences in the quality of life experienced by different people. People's appreciation of quality of life is not fixed.

Both environmental and health accounts have sought to develop methodologies to help rank the importance given to various factors identified within definitions of quality of life. In the former, this happened as a result of growing dissatisfaction among policy makers with economic indicators such as GNP per capita as the chief means of assessing a country's wealth creation during the 1960s when post-war austerity was yielding to unparalleled prosperity. Despite economic prosperity and the growth in living standards, research indicated that groups in the population continued to be dissatisfied with their quality of life (Rogerson, 1995). A Social Indicators Movement grew out of such concerns in the United States and in Europe. In Britain, the launch of *Social Trends*, and similar social reports in other countries, marked attempts to apply social

indicators in supplementing economic data about a country's development. A social indicator has been defined as any measure that describes some aspect of society. This approach was adopted, for example, by UNICEF in its annual State of the World's Children reports and basic indicators included: mortality rates (under 5 and under 1); number of births to number of child deaths; primary school enrolment; share of income of the poorest 40% and richest 20%; and per capita GNP (Ekins, Hillman, and Hutchinson, 1992).

Health-related quality of life research has been developed to assess the quality of life of individual patients and groups of patients, both actual and potential (Rogerson, 1995). During the 1980s, a time of scarce resources and of increasing demand for medical care, health economists used quality of life to aid decision making regarding treatment on the basis of predicted outcomes. This was in order to provide a measure against which resource allocation could be assessed (Maynard, 1987), that is, an attempt to develop a more equitable and rational way of rationing health care. A number of multi-dimensional health status indices, such as the Quality of Well-Being Scale, Euroqol, and most notably QALYs (quality-adjusted life years) have been developed to rate quality of life (Richardson and Nord, 1997). These descriptive systems commonly use categories such as: mobility, self-care; use of usual amenities/performance of normal social roles; pain/discomfort; and anxiety/depression with each category rated on a scale ranging from good to very poor. Rosser and Kind (1978) developed scales by which to account for patients' assessments of illness states. These were ranked according to distress and disability and to different levels of disease. Fallowfield (1990) suggests that despite the small sample sizes involved, this work formed the primary basis for most QALY valuations in England.

As QALYs place numeric values on health care there has been some debate about the way they are measured (Richardson and Nord, 1997). Not least is the concern that between no disability and no distress to high disability and severe distress the assessment process is less clear cut and different assessments tend to be made by different medical staff (Open University, 1993).

There is also a concern that QALYs may become dominated by the economics of cost-containment which might ride rough-shot over concerns about the limitations of assessment instruments and scores, and the lack of relationship between disease assessment and overall quality of life (McCarthy, 1995).

Both environmental and health accounts originally developed from the perspective of the researcher with little consideration for the views of those under study. In environmental accounts the use of 'expert' opinion to determine the components of quality of life has provoked considerable criticism. One of the most common criticisms has been that researchers would like to be able to reduce quality of life measurements to mere numbers and overlook what lies behind them. Carley, for example, has noted that

"even when such 'quantification' is not intentionally maladroit there is always the danger that researchers will become enamoured of their statistical procedures and models and lose sight of the complex political reality of policy problems." (Carley, 1981 p. 12)

Largely in response, subsequent environmental conceptualisations of quality of life have been based on the inclusion of personal, subjective components arising from the interaction between people and the environment. Factors such as the personal attributes of individuals (eg age, gender, social class), past and current experiences and the impact of relationships with other people, have been included, all of which are influential in shaping value systems and preferences (Rogerson, 1995). As has been noted:

"It is people's perceptions of their own well-being... or lack of well-being, that ultimately define the quality of their lives." (Pacione, 1980, p. 195)

In environment-related quality of life studies, the degree to which researchers' often unweighted rankings may differ when compared with members of the public has been revealed by the results of quality of life opinion surveys. These have shown that only one directly economic variable considered important by the researchers (low cost of living) made the top seven most important aspects of quality of life according to respondents in UK studies of towns and cities. Others aspects, such as employment, wage levels, housing costs and the time taken to travel to work, proved far less important to respondents than low rates of crime, a good health service and racial harmony. As a result, the conventional image of the North-South divide in the UK revealed by studies based largely on economic data was turned on its head: despite their relative lack of prosperity, it was the cities of the North and the West, with populations of less than 250,000, which emerged as the 'best' places to live. Larger cities, with populations over 250,000, despite their greater concentration of cultural facilities, employment opportunities and other positive quality of life factors scored badly, principally because of high crime rates and factors such as racial disharmony, pollution and high living costs (Grayson and Young, 1994).

In health accounts, criticisms of the reliance on practitioners as experts, and the lack of patient or other inputs in the identification of quality of life attributes parallels those found within environmental debates about quality of life. Researchers have found that doctors' assessments of quality of life can differ from those of patients (Slevin *et al.* reported in Bowling, 1991). There is also a significant difference between the views of clinicians and others involved in health care. Clinicians appear more inclined towards quality of life definitions that emphasise physical function, while psychological scientists are more likely to think about quality of life in terms of the complex inter-relationship between the physical, emotional and social domains (Fallowfield, 1990).

3.8.4 The urban focus of quality of life research

Many of the environmental accounts of quality of life have focused on life in towns and cities, where population densities can magnify problems, with people living and travelling around in close proximity to each other. In urban environments where the potential risks for traffic-related injury and violent crime are perceived as being more likely outcomes than in rural areas extra vigilance on the part of the individual is required. Road transport is often high on the list of public concerns, as noted in Chapter 2 (British Social Attitudes, 1997; Barclay Sitesavers/Groundwork, 1999). Related issues are the loss or degradation of urban green space; the decay in the infrastructure; and the squalor caused by dog fouling and litter in the streets. All affect personal quality of life to a greater or lesser degree. Research suggests that the ideal city is safe, healthy, cheap, well-serviced with shops and racially harmonious. Money, jobs and shelter may be necessary prerequisites but the highest quality of life is defined by other characteristics (Rogerson, Findlay, and Morris, 1988).

Similar discussions of what makes for cities with good quality of life have been described by early proponents of the WHO Healthy Cities project. Hancock and Duhl identify the importance of the physical and social environment and suggest that

“a healthy city would have a clean, safe, high quality physical environment and ... The community would be strong, mutually supportive and non-exploitative, participating actively in community governance.” (Hancock and Duhl, 1986 p. 43)

The WHO has stated that the quality of a city's life depends on the management of its natural resources, on water and on air quality, and on a form of town planning that is designed to meet the needs of current and future generations. It is also dependent on the creation of environments which are supportive of human contacts and co-existence of different ethnic, cultural and religious groups (WHO, 1994).

The negative aspects of urban life noted above are the reasons given by a considerable percentage of the urban population for preferring a rural life. The 1992 English Regional Lifestyles report found, for example, that two-thirds of its 1,000 sample prefer to live in the country rather than the city because of its open space, cleanliness, quietness and lack of stress. One in ten urban dwellers actually planned to move in the next five years while another one in five would move to the countryside if they could afford to (Mintel International, 1992). This would make them almost wholly dependent on private motorised transport for their access needs. As the Introduction to the 'Transport' section of a 1996 White Paper 'Rural England' notes:

"In the countryside, private transport is now the key to maintaining the rural quality of life."

(Department of the Environment, 1996)

Many people put a far greater value on natural than built environments, and associate cities with a form of enforced sensory deprivation in which experience of the 'real' world is denied. They cannot see the horizon, smell fresh air, or mark the change in the seasons; their daily lives are spent in artificially lit and artificially ventilated buildings; and they cannot stand back from the cluttered world and see it in context (Grayson and Young, 1994). This is not, however, only a UK phenomenon, as the perceived malaise of urban living can be found in both perceptions of urban life and in the decline of urban populations in other European countries. In Copenhagen, for example, it has been reported that perceptions about poor air quality have led more affluent households to leave the city (see Chapter 6).

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Chapter 4

Research methods and methodology

4.1 Introduction

This chapter is set out in four sections. Section 4.2 describes the range of survey methods used in the study. Section 4.3 addresses methodological issues and the approach that underpins the methods used. Section 4.4 discusses the design, testing, and application of the methods in order to address the research questions. The final section provides a reflection on the research process and considers a number of issues concerned with it including the rigour required of such a study.

As discussed in chapter 1, this study focuses on Health for All and transport between 1986-1996. These dates reflect the launching, in 1986, of the WHO Healthy Cities project and in the following years the establishment in European towns and cities of Health for All projects. The main body of fieldwork commenced in 1995 and was completed in 1996.

4.1.1 Research aims

Following reviews of transport and health literatures, in which key themes and debates were identified, the aims of the research were refined. It is worth re-stating the aims here. They were to:

- compare English, Dutch and Danish approaches to intersectoral collaboration on transport and health using specific case study examples and examine the role of Health for All in each case
- assess the influence of Health for All on transport planning policies in each case
- highlight from the case examples of intersectoral collaboration on transport and health where transport policies were influenced by Health for All, and the policies, practices and other methods used

- identify the potential for health promoting transport planning in England.

The research questions flow out of the aims of the research. Key questions were identified and these were:

- whether Health for All had any influence on transport planning in the cities under study?
- where Health for All did have some influence, how much and what kind of influence did it have?
- what were the barriers encountered by Health for All in attempts to influence transport planning?
- what evidence was there of intersectoral working and the limits to this?
- what were the most significant drivers of transport planning policy in the cities under study?
- what lessons can be learnt about possible ways forward for Health for All/Healthy Cities in trying to influence transport planning policy?

4.2 Methods used

4.2.1 Case study approach

Case studies are used to explore contemporary phenomena, especially where a range of issues are involved. An advantage lies in the depth of knowledge case studies provide in illuminating the workings of a system (Gluckman, in Donovan, 1986). The aims of this research, to explore the influence of Health for All on transport planning policy, fits well, therefore, with the case study approach. As discussed in Chapter 1, a stimulus for the research was the view that health promoting transport policies might be outcomes of concerns for the environment rather than Health for All policies but that this might be changing as Health for All became more established. Focusing attention on three specific cities meant that detailed data could be gathered about Health for All and transport policy in each city and comparisons made between them.

When archival sources, and semi-structured interviews are used consistently within different sites, comparisons can be made between sites as to the influence of a particular policy or range of policies, and theoretical propositions generated that may be generalisable. Comparability and translatability are critical to the study given that the research questions concerning health promoting transport seek to uncover the potential translatability of health promoting transport planning policies between cities. As a result, case studies can be used to make a proposal to policy makers (Hall and Hall, 1996). There are, however, limitations to comparability and translatability of sites studied simply because there will always be idiosyncrasies within any particular situation. This implies that the issue of translatability is concerned with 'degree of fit' rather than absolute fit (Schofield, 1993).

4.2.2 Archival research

Archival sources of data provided official accounts of the health and transport policies and programmes in Denmark, the Netherlands and England. These were used as a source of comparison with the interview data. Archival sources set out national government policy including perspectives on policy implementation and plans and programmes for new and on-going policies. Key sources for the study were national government policy reports, including White Papers, which set out programmes for specific areas of public policy: transport; environment; and health. Most information about each country was gathered through obtaining such reports. With regards to health data, some information was gathered from World Health Organisation (Europe) and Organisation for Economic and Cultural Development (OECD) publications. Both publish data on aspects of health provided by their Member States.

In Denmark archival sources consisted of national government documents and policy papers from the Road Directorate (the government transport research centre), the Ministry of Transport, the Ministry of the Environment and Energy, and the Ministry of Health. Dutch archival sources consisted of data from: the Ministry of Transport, Public Works and Water Management; the

Ministry of Housing, Physical Planning and Environment; and the Ministry of Health, Welfare and Cultural Affairs. In addition, data was also drawn from National Institute of Public Health and Environmental Protection publications. In England, the Departments of Transport, Environment, and Health were the main sources. In addition, data was obtained from reports by the Association of County Councils and the Royal Commission on Environmental Pollution.

Much of the implementation of policy is the responsibility of city governments. Archival sources therefore also included data from the city municipal authorities. In addition, in England, because health services are the responsibility of the National Health Service rather than the municipal authority (as in Denmark and the Netherlands), reports from the local health authority were obtained.

In the context of the research aims, it has been important to set out government policies on Health for All and the achievement of the 38 targets (in chapters 5, 6 and 7), having noted in Chapter 3 that the Health for All targets were to be a means by which WHO Members States could measure progress towards the attainment of Health for All. Similarly, the development and direction of transport policies in Denmark, the Netherlands, and England (in chapters 5, 6 and 7) provides a framework against which the perspectives of interviewees could be compared and contextualised.

4.2.3 Fieldwork interviews

In this study the snowball sampling technique was selected as an efficient means by which to identify key officials in the city authorities involved in transport and health work, particularly in order to establish who from municipal government and health services played a significant role in projects such as Health for All or Healthy Cities. Snowball sampling is used by researchers to choose those individuals who seem initially to be key research subjects and then use them to supply other informants. This approach has been applied in ethnographical studies of health

issues (Donovan, 1986). Researchers have noted that samples could be biased because of the reliance on a few people to identify a larger number (Hall and Hall, 1996; Grbich, 1999). In this study this potential problem was minimised because the officials who were interviewed had been identified by a number of contacts as key actors. It is worth noting that none of the potential interviewees identified declined to be interviewed. In addition, several key actors were also identified as a result of having had papers on aspects of Health for All or health and transport published.

The semi-structured interview with open-ended questions and a flexible question schedule was chosen because, it can come close to a conversation style discussion in which it is possible to probe and tease out issues and problems which may not be given voice in some archival sources. For example, governments may want to give an impression of progress on implementation of a policy and so not highlight difficulties which have been found among practitioners. As a result, government policy papers and reports on progress may not allude to these. Progressive focusing of questions from the general to the specific can help as the interview proceeds in enabling the interviewee to give their account of the issues under discussion. For example, in this study, interviews begin with general questions about the work of the interviewee and were increasingly focused to specific issues relating to collaboration on transport and health. In addition, through semi-structured interviews further questions can be introduced as issues arise from data sources (Britten, 1995). One example from the fieldwork interviews was where new information of general relevance was gathered during the interview process and incorporated into subsequent interview questions. I learned during the course of the first interview in Copenhagen that health promotion legislation had recently been passed which had some influence on the current and future work of some of my interviewees. I was able to amend my questionnaire itinerary slightly in order to gauge views on the importance of this legislation.

A pilot case study was undertaken from summer 1994 to January 1995 to ensure that semi-structured interviews would be appropriate in creating a balance between information seeking out particular issues and covering opportunities for more wide ranging discussion. This pilot study is discussed in sections 4.4.1 and 4.4.2.

4.2.4 Triangulation

According to Miles and Huberman (1984), it was Webb and colleagues who coined the phrase 'triangulation of measurement' in 1965, and suggested that social scientists are likely to exhibit greater confidence in their findings when they are derived from more than one method of investigation. Since then, researchers have generally viewed the main message of the idea of triangulation as entailing a need to employ at least two methods of investigation and hence at least two types of data (Bryman, 1988). It has also been noted that the essence of the triangulation rationale is the fallibility of any single measure as a representation of social phenomena and psychological constructs (Fielding and Fielding, 1986). Denzin (1970) identified four basic types of triangulation:

- data triangulation: the use of a variety of data sources in a study;
- investigator triangulation: the use of several researchers or evaluators;
- theory triangulation: the use of multiple perspectives to interpret a single set of data;
- methodological triangulation: the use of multiple methods to study a single problem.

An important feature of triangulation is not the simple combination of different kinds of data, but the attempt to relate them so as to counteract the threat to validity identified in each. It is also a means by which to add breath and depth to the analysis. Issues which may be barely touched on or even missed in one approach may be expanded upon or highlighted through another (Kellaheer, Peace and Willcocks, 1990).

While combining methods and data can help the researcher's claim for the validity of his or her conclusions if they are shown to provide mutual confirmation, there has to be some degree of caution in the application of triangulation. Firstly, errors in each method could lead to mutual confirmation, and there is also a risk that the researcher picks out points of similarity in the data and ignores differences. This latter point highlights another important aspect of triangulation, that the possibility of discrepant findings also exists and are not unusual (Bryman, 1988). Fielding and Fielding (1986) identify discrepancies as one of three ways of considering the comparability of data. In addition to the combining of data generated by different methods, data can be in conflict, where data from one methodology may conflict with another, identifying points of dissonance. In this study, triangulation has been applied in the form of comparisons between the actions and ideas stated by interviewees and that of the archival sources. Differences between what may be claimed in archival sources and what may be experienced by interviewees who have day-to-day responsibility for the subject area, can serve to reveal difficulties with implementing policies at the local level. A third way of considering the comparability of data is by indefinite triangulation, that the inevitability of different accounts can be used to highlight different interpretation of events. In this study this way can be applied to differences between interviewee accounts.

Fielding and Fielding (1986) also suggest that as many guides as possible should be used to home in on the topic or theme. In particular, they suggest that at least one method that reveals the structural aspects of a problem should be used; and also a method that looks at actual interactions. This way the meaning of events or features for all those involved can be considered.

This study has sought to address what can be identified as 'structural aspects of a problem' in that archival sources locate the aspirations of improved health in Europe through Health for All and support for this by national governments. Moreover, the interview data has helped in gaining insights from those key actors in the case study cities working to implement Health for All and those in the transport sectors with whom they needed to collaborate, so applying a method which

'looks at actual interactions'. This has involved methodological triangulation, using the interviews and the archival research, revealing the extent to which Health for All policies and practices are in accord or in tension and their significance within transport planning.

4.3 Methodological approach

4.3.1 Qualitative research

The study is grounded in a qualitative tradition because qualitative approaches lend themselves to complex social phenomena, being multi-faceted and theory building. The goal of qualitative research is not to produce a standardised set of results that can be replicated by any other researcher in the same situation (theory testing), as is usually the case with quantitative research. Instead, qualitative research seeks to produce a coherent and illuminating description of, and perspective on, a situation that is based on, and consistent with, detailed study of that situation (theory building) (Schofield, 1993). As discussed above, this has been undertaken in the study through the use of case studies. Qualitative research depends in much larger part than quantitative research on producing a convincing account. The combination of archival sources from both national and local government and interview data focused on three cities provides rich and detailed accounts of the influence of Health for All on transport planning policy.

It has been argued that the social world can be studied using the same methodological perspectives and techniques as traditionally have been used to study the natural world. This methodology is known as the positivistic approach to social research (Wing, 1998). The epistemological perspective that largely informs positivism is one which sees social phenomena as an overall system external to individual social actors, and which is quantifiable. Quantitative researchers presume that there is a single material 'reality' that exists independently 'out there' (Grbich, 1999). Such approaches have traditionally been seen to give respectability and neutrality to research (Donovan, 1986; Giddens, 1993). Yet the observation of facts or use of numerical data by the researcher also involves subjectivity and interpretation in terms, for example, of the

choices made about what to measure or observe (Mays and Pope, 1995). In addition, quantitative research methods tend to be inflexible if new data comes to light whereas qualitative research is more fluid and is able to adapt in response (Bryman, 1984). For such reasons, a quantitative approach was rejected.

In contrast, a qualitative approach sees the world as socially constructed by the researcher and other participants, and that the two are interwoven. Most qualitative researchers believe that 'truth' lies in gaining an understanding of the actions, beliefs and values of others, from within the participant's frame of reference (Grbich, 1999). The authenticity and credibility of qualitative research relies on the construction of theory based on concepts and issues which have emerged from the data (Strauss and Corbin, 1990). Such data can then be set along side archival sources which, in this study, provided a policy context and a set of data for comparison.

To comprehend complex social phenomena, such as the range of barriers to collaboration identified in the fieldwork chapters, the research has sought to understand the perspectives of the people interviewed and the meanings which they attach to their subject domains. In recognising the importance and relationship of socially constructed perspectives to social action there is a need for researchers to be able to identify with their subjects' perspective. Weber developed this idea of empathy ('verstehen'), realising that the outcomes of social interactions were not necessarily what the actor intended but that such interactions are a necessary though not sufficient explanation for understanding social behaviour (Hall and Hall, 1996).

Weber viewed as important the idea of free thinking individuals who make sense of the world by attaching meanings to social phenomena. He asserted that people construct their social worlds through social interaction and interpretation. This view posits that people construct and live within multiple realities, both as individuals and collectively (Berger and Luckmann, 1966). As Giddens has noted, unlike the natural world, which has no intrinsic meaning, the social world is inherently

meaningful because it is made by people and created and re-created in every social encounter (Giddens, 1993).

The interview structure allowed the informants to create data through the social interaction in the interview. This approach invests control over the production of knowledge in the subject not the researcher (Hall and Hall, 1996). The researcher seeks the role of the student, trying to understand what is happening and how the situation connects with others (Donovan, 1986) rather than fitting the information to reflect the researchers' own interpretation of the social world (Wilson, 1993).

4.4 Data collection

4.4.1 Choice of pilot study location

During 1994-1995 a pilot study was undertaken using semi-structured interviews. The pilot study was of Camden, London. The three main reasons why Camden was chosen were:

- Camden Council is a highway authority
- Camden had been designated as an official WHO designated Healthy City;
- some key contacts were already established.

Firstly, Camden Council's Planning and Environment Department was responsible for highways (a highways authority rather than just a planning authority) and consequently had direct control over transport policy in the borough. The Health for All project could, therefore, collaborate directly with those officials responsible for transport policy rather than if Camden Council had been only a planning authority. This meant that one possible obstacle to intersectoral collaboration on health and transport could be avoided. During the period of study up to 1996 some English cities, such as Bristol and Leicester, were not highway authorities and so were not directly responsible for highways and transport planning.

Secondly, Camden was a WHO designated Healthy City which meant that certain actions would have been taken by Camden Council in order to meet criteria determined by the WHO (as discussed in chapter 3). This included devoting resources to the project, such as staff, offices, and a management structure for reporting to key agencies such as Camden Council and the local health authority. Thirdly, I had an important contact through the Director of Public Health at Camden and Islington Health Authority, and had previously met the Director of Camden Council's Planning and Environment Department.

4.4.2 Pilot study approach

My search for key actors began with the local Director of Public Health in Camden and Islington Health Authority. I sought his advice as to whom such people might include, using the snowballing technique described above, where interviewees recommend others who might, in their experience and given the research area, be important people to contact. Having identified the Council's Health Coordinator, and the Health for All Coordinator based in the voluntary sector, both with day to day responsibilities for progressing the Healthy Cities project, I was able to augment this by further 'snowballing'. In all, I interviewed five key actors from the health sector and local authority involved with the Healthy City project in Camden. Archival source material was also gathered such as Camden Council reports, and information from the WHO (Europe), as well as secondary sources on the work of the project, including articles in professional journals.

Piloting was important to test out and refine interview questions. It also provided an opportunity to trial the ordering of questions, as well as helping to clarify the appropriateness of the interview structure. A set of questions was posted in advance of the interview, having first made contact with the interviewee via telephone. The questions were accompanied by a letter on University headed paper which set out what issues the research was trying to address. I restated this information at the beginning of the interview to ensure that interviewees, with all their other tasks, were aware of the aims of the research.

The pilot interviews lasted an hour and a quarter on average and, having gained consent, were taped recorded. They were conducted in a semi-structured style in order to gain responses to prepared questions and allow some scope to explore issues which emerged through discussion. This format also allowed time for supplementary questions. For example, the Director of Camden Council's Planning and Environment Department identified the lack of Chief Executive support for Healthy Cities. He stated that the Chief Executive was interested in the Health of the Nation, the government's health strategy, and so Healthy Cities advocates sought to progress certain aspects of Health for All policy which could be labelled as part of the Health of the Nation strategy. In response, I asked a supplementary question of whether the 'the Health of the Nation had been able to get initiatives developed whereas perhaps Healthy Cities had not?'

Interviews were transcribed by myself, and then posted to the interviewees, each of whom was asked to check the text for accuracy. In all but one case only minor corrections or clarifications were requested by interviewees and these were made to the transcripts. Corrections were often to the sequence of events, something which might not have been so clear given the flow of the interviews. One interviewee made some notes on the draft of her transcript expanding on certain points, as well as providing some clarifications on particular issues. A report was then drafted as an exercise in analysing a Healthy Cities project in order to explore issues involved in its development. In the report interviewees names were not given. This report was sent to each of the interviewees. Some positive responses were received and no negative ones offered. One of the interviewees, who had moved to a public health post elsewhere in England, specifically requested a copy of the report for a member of his staff who was undertaking a project on Healthy Cities.

The pilot study of Camden Healthy City Project was an important exercise in identifying, refining and refocusing the questions. In particular, questions had to be adapted to 'fit' the particular role

of each interviewee. For example, the Director of Planning and Environment at Camden Council and the Director of Public Health at the local Health Authority had differing roles, working for different organisations. This did not mean, however, that the issues about Healthy Cities, inter-sectoral collaboration, and transport were omitted but rather the questions were tailored to address the particular organisation and profession within which the interviewee worked. As interviews took place, additional information was also gained which helped to refine questions in the subsequent interviews. For example, reports to Camden Council on initiatives of the Camden Healthy Cities provided evidence of types of initiatives which had a transport focus. This then helped to refine questions, and acted as means by which subjects could be introduced.

The pilot study was also important in gaining insights into the application of triangulation. Comparing and contrasting archival data with data generated through the pilot interviews enabled me to plan for the main study. For example, interview questions addressed issues identified through archival data in order to test to what degree different data sources were mutually confirming. The piloting helped to identify that questions and their order needed to be refined in order that the triangulation process could better tease out underlying issues such as those not directly addressed in archival data and reveal differences in the accounts.

4.4.3 Main study: choice of fieldwork locations and countries of study

Denmark, the Netherlands, and England were selected for the main study. In terms of health policy, the national governments had each made a commitment to Health for All and this was a critical factor given the aim of the study. Within the countries the cities of Copenhagen, Groningen, and Sheffield were selected, in part, because it was known that each city was involved in work to progress Health for All.

From a transport perspective, each city is a highway authority and so responsible for decision making on transport planning policy within its boundary rather than responsibility resting with a

county, regional or national authority, as was the case with the pilot study location of Camden. The three cities had also been able to record relatively high percentage shares of travel for walking, cycling and public transport over the preceding decades compared with other cities in their own countries and they had substantially been able to halt the growth of private car use. Selection was, therefore, based in part on this shared achievement, uncommon among most of Europe's cities.

Their approaches to transport planning policy were known, however, to be distinct from each others' and local policies had also been influenced differently by national government policy. The varying approaches was a further reason for their selection. A study of the different approaches could reveal the extent to which intersectoral collaboration on health and transport had been a factor in the development of the transport policies and reasons for this. The differences in approach are briefly outlined below and addressed in detail in the following chapters.

Copenhagen has a long history of planning to steer transport mode choice to modes other than the car, supported by speed control and traffic restraint measures. Combined with strong national environmental policies and a high car import tariff, it has been one of the few European cities to report a decline in car use in recent decades. Groningen has been at the forefront of Dutch environment-led transport policy, implementing land use planning and traffic restraint measures to increase the use of alternatives to the car. As a result, distances within the city are relatively short, and this combined with a Traffic Circulation Plan, made Groningen an attractive centre for pedestrian, public transport users and cyclists. Sheffield was the only city in England where a cheap fares policy had operated for over a decade. It led to an actual increase in distance travelled by bus and a small decline in car use. The policy ended in 1986 and since that time car ownership in Sheffield has risen faster than the national average and the share of bus passengers has fallen substantially. Up until 1996 national transport policy had been largely

focused on accommodating the growth in motor traffic, although plans for a new Supertram were being progressed by the City Council.

4.4.4 Identification of interviewees

In the main study fourteen interviews were undertaken. Identification of the interviewees was via a number of means. I sought to interview Health For All/Healthy City Coordinators, whose contact details were readily obtainable from both national Health for All network offices and WHO Europe, since it was the responsibility of such officials to seek to develop intersectoral dialogue and collaboration with officials in the transport planning professions, among others, in order that Health for All goals could be achieved. Exploration of the literature relating to health and transport issues helped to locate some key informants and this led to communication with them by letter, fax and phone calls. This was augmented by use of the snowballing technique. Through these techniques I identified a group of key actors, usually four or five, each playing an active role in the policy areas of health promotion and transport in Copenhagen, Groningen, and Sheffield.

4.4.5 Interview timetable

The interviews were undertaken between May 1995 and February 1996. They each lasted between one hour and one and a half hours. For practical reasons the Dutch and Danish interviews were undertaken during the course of week-long visits. In England, there was greater flexibility and the interviews were carried out over the course of two weeks.

The time-tabling logistics meant that the Danish interviews were undertaken first, in May 1995, and were mostly transcribed by the time of the visit to the Netherlands in October. All continental interviews had been transcribed by the time of the interviews held in Sheffield in February 1996.

4.4.6 Research setting

For practical reasons all interviews took place in the offices of the interviewees, and were mostly conducted in quiet rooms away from other staff, not least to ensure that they were not interrupted by phone calls and other distractions. It has been suggested that those interviewed in the workplace tend to give short, 'to the point' answers, due to the environment and time constraints (Hall and Hall, 1996). I did not find this to be the case. In Denmark and the Netherlands it was likely that more time had been assigned by the interviewees because a researcher had come from abroad.

4.4.7 Interview format and process

Interviews in the study were conducted in a face-to-face, semi-structured style, as discussed for the Pilot study. As noted previously, semi-structured interviews are conducted on the basis of a loose structure consisting of open ended questions that define an area to be explored, and from which the interviewer or interviewee may diverge in order to pursue an idea in more detail (Britten, 1995). My aim was to avoid closed discussion in which I would be perceived by the interviewee to require particular kinds of responses based on pre-conceived views.

While the interviews were conducted in as consistent a manner as possible, better rapport was established with some interviewees than others. Establishing rapport between the interviewer and interviewee is a research technique used in this study and one which helps to minimise differences between the two, such as status, power and knowledge. This does not have to conflict with the idea of the researcher as 'student', as discussed earlier. The role of student is one which maintains an openness of mind and gives value and respect to the views of the interviewee. The idea of rapport rests on a presumption that the interview should be planned to create a sense of equality and trust that will enable the free flow of communication between interviewer and interviewee in order to better understand the interviewee's perspective (Grbich, 1999).

The interviewer's introduction can play an important part in setting interviewees at their ease. In most cases there was time at the beginning before the interview began and the tape recorder was set up for some informal discussion. This gave time to begin to establish some rapport. The difficulty was to establish rapport with each interviewee while seeking to remain as objective as possible. The interview format was easiest to manage where I had not had contact with the interviewee prior to the interview arrangements. This was particularly the case when interviews were undertaken in Denmark and the Netherlands.

I began the interviews by introducing myself, the research area, and sought to ensure that the interviewee felt he or she understood the purpose of the interview. I explained briefly that my research was focused on intersectoral collaboration on health and transport. In arranging interviews I had previously sent all interviewees a written two page summary of my research study, although it was evident that not all had had time to read this. As reported above, the questions had been refined in the light of my experiences undertaking the Camden pilot study, through reading secondary literature, and from learning about the structures and ways of working within health authority and local government systems. Interviews were tape recorded, having obtained prior permission to do so from the interviewees.

Questions began with a general enquiry about the role of the interviewee in relation to the department and organisation they were employed by. The interview then moved on to more specific issues, either raised as they emerged through discussion and through progressive focusing of the questions so that they became more specific as the interview developed. As an example, the first question to the Healthy Cities project Officer in Copenhagen was

"Can you tell me something about your role in relation to the Healthy Cities Project?"

The fourth question was more specific.

"Can you tell me something about the [Healthy City] Plan and the aspects particularly related to transport?"

The Healthy City Plan had already been mentioned by the Healthy Cities project Officer in responding to a previous question. Where responses were vague or needed clarification questions were often followed up with:

"Can you give me an example..."

I sought to use standard probing questions to explore some issues further where the initial response to a question had been vague or seemed to be partial. For example, in interviewing the transportation planner in Copenhagen I asked about who his work led him to collaborate with in other sectors. The initial response was to state that

"we have collaboration with the public transport board, the bus company, the police of course, and the planning people in the Lord Mayor's department if you take them as another sector. So those are the main people I have cooperation with. Of course the surrounding municipalities and the State, the State Road department, we have some small cooperation there."

I then explained that

"the main emphasis of the question is about people from other professions not concerned principally with transport."

This led to a reply which identified some key health contacts.

"OK, other professions. Then I will say that it is mainly the Environmental Agency and the health people within the municipality. Also, with the health agency, Mr Jens Egsgaard, who you have interviewed, and there has been that cooperation about this Healthy City Plan with a chapter on traffic, which you know. We have some cooperation with the Environmental Agency in themes about air pollution and noise and things like that."

Similarly, in Sheffield, in interviewing the transportation planners, I asked the question

"Does your work involve you in collaborating with people from other sectors? If so, who?"

The response identified a range of people from different City Council departments.

"The process that we are going through at the moment ... is to say that we are obviously linked with Design, Building Services, our engineers in the sense that we are meant to think of things that they are meant to implement. And they have also got development controls. That process is entirely replicated by our planning colleagues. All the major funding programmes at the moment like SRB mean that we have to put in joint bids so planning is where we collaborate together. From there we broaden out into environmental health, looking at housing and traffic calming, giving the streets back to people. It is going to be a lot easier if we combine with the Housing Renewal Areas. The big one that we are interested in at the moment from our Transportation Policy unit is the change in attitudes."

I then asked,

"What about the transport and health work?"

The response was

"The transport and health group's work covers Sheffield and Rotherham. I think that that has come out of a lot of the work with environmental protection on pollution. I haven't got a comprehensive list of who is involved but as far as Sheffield City Council goes transportation is included and there are various sections, linked with Healthy Sheffield and Sheffield Health. There is also an executive committee liaison group which is the secretariat for a partnership group to promote Sheffield..."

Through such a format I was seeking to allow a free-flowing discussion to take place. The interviewee could, in this interview structure, draw on a range of experiences in giving his/her responses to the original and any supplementary questions raised during the discussion.

Transcriptions of all interviews were made as soon as practically possible, generally within two weeks of the interview. As in the Pilot study, transcripts were sent to interviewees for checking. Again, only minor amendments were suggested, such as changes to dates, department and staff titles, and these were made. Transcriptions were supplemented by the addition of reflective notes made after each interview. This reflexive process is discussed in section 4.5.4

4.4.8 Archival research processes and data collection

Archival sources were gathered partly as a result of having read secondary sources which identified new policy initiatives and publications prior to, and during, the period of study. For example, the publications of the Dutch *National Environmental Policy Plan* and the *Second Transport Structure Plan* received significant coverage in British planning and transport journals at the time. Often archival sources were used to identify other sources of relevance to the research areas since many local and national policy papers referred to previous and linking policies. Some documents were sent

by civil servants and municipal government officials in response to written requests for policy papers covering specific issues on transport, environment and health. Others were gathered having made contact with the interviewees both prior to the interviews taking place and during, for example, where specific issues and areas of interest had been identified during discussion. Lastly, in formulating the ideas for the thesis over a number of years I had gathered some archival materials from Danish and Dutch national and municipal government officials, some of which were obtained through attendance at conferences in those countries. As a result of this process a number of archival sources were identified several times by different contacts, and through journal articles, suggesting that these were key documents.

In terms of selection of data for analysis, for material relating to Health for All from national governments, the task has been to glean information from a number of health department policy papers obtained in order to ascertain the level of support for the initiative. These have not been so numerous as to make selection problematic as Health for All appears in most government policy papers as one issue among many. For example, in the 1992 English Health White Paper *The Health of the Nation* the main reference to Health for All appears on page 26 in a document of some 126 pages. With regards to national government archival sources on transport and environment, selection for analysis has been directed by identification of the primary goals of policy and from which municipal transport policy has been guided. For example, in both Denmark and the Netherlands, where environmental concerns have significantly influenced the shaping of national transport planning policies this is reflected in policies at the municipal level.

Selection of data from archival sources at the municipal government level has largely been directed by the aim of highlighting what the policy objectives are on the issues of transport, environment and health and to illustrate what links have been made between the transport and health sectors in particular.

Access to archival data was anticipated to be more difficult to obtain from the Netherlands and Denmark than England and so careful time-tabling was involved to enable correspondence with Dutch and Danish national and municipal government departments and research institutions. It was important to have obtained archival source material prior to the field work in order to contextualise the information gathered during the course of the interviews, and so letters were dispatched shortly after study sites were identified, some six months before the first fieldwork began. Some additional archival source material was obtained during the course of the interview visits as a result of documents being discussed by interviewees. These included Ministry of Health and Groningen City Council reports in the Netherlands and Healthy City publications in Copenhagen. Through the material gathered, and through secondary literature sources being amassed for the literature reviews on transport and on health policy, gaps in archival sources were identified. Further relevant publications were obtained through contact with national transport, environment, health ministries, municipal government departments, and through university library services.

An additional issue was that while most Dutch and Danish publications obtained were written in English, a small number were not. Translators then had to be sought. These publications were not translated wholesale but rather specific chapters which had been identified as relevant between the translator and myself.

4.4.9 Data analysis

An iterative process was followed comprising several levels of analysis. Having gathered together the archival sources and interview data, the next task was to identify key themes by listing them. This was undertaken by writing issues down on separate sheets of paper to generate coherent groupings. Firstly, key themes were identified in the archival data. These embodied major groups of issues such as those relating to intersectoral collaboration and how barriers to this could be overcome, and national government perspectives on the links between health and transport. Similarly, transcriptions of the interview data were analysed and summaries made of the issues they addressed. This was

undertaken by looking through the data for evidence of how the interviewees perceived their work involving them in intersectoral collaboration on health and transport, with whom, and the types of issues which they had confronted, such as specific barriers to, aids to, and successes at, collaboration or action. Identifying what transport sector interviewees saw as the drivers of transport policy was important, and whether health was seen to be contained within policy drivers, such as 'quality of life'. This exercise was undertaken twice in order to compare issues identified at a first analysis with those of a second which was undertaken some months later.

These were then grouped according to the issue types, such as barriers to inter-departmental collaboration within municipal government, and claims for the influence of national government policy. These were then sub-divided by country in order to collate data for each case study. From these groupings six key themes were identified. These were:

- quantitative and qualitative approaches to health and transport
- inter-departmental and inter-sectoral collaboration and barriers to these
- legal dimensions of health promotion
- health and quality of life issues
- the influence of national government policies
- environmental concerns as a driver of transport planning policy change.

In the process, some themes were recognised to be of greater or lesser relevance in specific countries or between different professions. For example, health promotion legislation had been enacted in Denmark and the Netherlands in 1994 and 1989 respectively but not in England. During this process it was recognised that more detailed knowledge was required of inter-departmental and inter-sectoral collaboration, and quality of life. This was in order that the literature review chapters were able to provide a theoretical framework when such issues were raised during the discussions of the interviews. Literature reviews on departmental and inter-sectoral collaboration, and quality of life were therefore undertaken and then woven into the transport, and health literature review chapters.

The next task was to develop a structure for drafts of the three case study chapters. Archival sources were first grouped according to subject areas, namely health and transport. Sections were then drafted setting out the development of policies of national government policies in both areas. These highlighted key policy statements and papers. A further section provided evidence from archival sources of existing collaboration on health and transport at the national government level. Archival sources, largely drawn from municipal governments, were also analysed in order to identify policy developments and statements on health and Health for All, and transport planning at the city level. Information on Health for All was relatively easy to identify, since, as noted earlier, in national government health policy documents only a few paragraphs were generally devoted to the area. Regarding city level transport planning, key issues were drawn out by identification of key policy aims and objectives and under-pinning policies such as land use planning. The six key themes were then used to help structure sections focused largely on the interview data. Drafts of these chapters were subsequently revised and refined. In undertaking the revisions the original tape recordings of the interviews were replayed and new notes taken, so as to remind myself of the interviews, and also to provide an opportunity to reassess whether any issues now appeared to have greater significance than I had previously thought. Further revisions to the drafts were made as a result of this exercise.

4.5 Reflections on the research process

4.5.1 Researcher bias

It is recognised that researchers cannot stand apart in qualitative, interpretative research but are engaged in generating the data (Denzin, 1989). For example, it is well documented that the way interviewees respond in a face-to-face interview situation can depend on who the interviewer is and the way they conduct themselves (Mies, 1993; Grbich, 1999). A case-in-point in this study was that I recognised that interviews worked least effectively in the few cases where I had previously had contact with interviewees and so it was more difficult to assume the role of student, as was the case with the Sheffield City Council transportation staff. The effect was to weaken attempts to avoid closed

discussions as presumptions tended to be made by myself as interviewer drawing on prior knowledge, and particular interpretations may have been made of statements made by the interviewees.

Researcher bias cannot be entirely eliminated, although triangulation can gauge the extent to which this bias exists through the perspectives of other interviewees and documentary sources. It is therefore particularly important that the presentation of the research allows the reader, as far as possible, to distinguish the data, the analytic framework used, and the interpretation (Dingwall, 1992).

4.5.2 Ethical issues

Accountability of the researcher to the researched is the key ethical issue in this study. Firstly, locating my position as a research student was important in providing some assurance that the project I was undertaking was sanctioned by a known university. Most, if not all, of the interviewees are likely to have had a university education in order to have gained their positions so there was some likelihood that they would have been more at ease with the general nature of research than if, for example, I had been interviewing semi or unskilled manual workers.

It was important, nonetheless, to provide interviewees with a clear understanding of the research, and guarantee the confidentiality of the interview transcript - that it would only be seen by my supervisors. As discussed above, gaining consent and providing information were integral to the study approach. As well as sending transcripts of their interviews to interviewees, there was additional contact with some of them in order to obtain further archival source data and this provided opportunities to update them as to the progress of the research. In addition, some documents were provided for those interviewees who had requested information on aspects of English policy. For example, the National Health Cities Network Coordinator in Copenhagen requested a copy of the 1995 King's Fund report *Tackling Inequalities in Health*.

As an interviewer I needed to consider how I was perceived by the interviewees and the effects of my class, race, age and sex. While the study exclusively involved interviews with white middle class interviewees, half of the interviewees were women. Understanding the interviewee's perspective is important from an ethical stance in that the data created should not be misinterpreted or misrepresented or presented out of context. Developing rapport is an important means by which to lessen gender barriers which may reduce the richness of the data generated. The issue of rapport has been discussed above.

As a male in his mid 30s I was often, I guessed, five to ten years the junior of interviewees. While I could not discern the effect of this on the interviewees I believe that the relatively small age gap may have helped create a sense of greater equality than if I had been in my early to mid 20s. Reflecting on the interview experiences, most interviewees appeared at ease, which may also reflect the level of competence and self-assuredness required of them in order to undertake their roles, and some success in the development of rapport. I also believed that I did convey some enthusiasm and interest for the subject area during my contact with the interviewees and that this too was relatively helpful in developing rapport.

4.5.3 Cultural influences

Given that the first languages in both Denmark and the Netherlands are not English, and I spoke neither Danish nor Dutch, there was a potential problem of identifying for interview certain key actors where there was no common language. In practice, however, this did not arise as all interviews were competent speakers in English, although some were evidently more fluent than others. I was aware of the need to ensure questions were clearly understood. This meant in practice that questions were sometimes either repeated or explained more fully and the pace of the interview discussion was affected to some degree by each interviewee's fluency in speaking in English. As a result, there was a tendency for some interviewees to check at fairly regular intervals whether I understood the replies being given or for me to give confirming statements to show that I had understood what they were

saying. When references were made to procedures, organisations etc... of which I was not aware, time was generally made to explain these. As English is the second language in these countries, some of the sentence construction and words used appear clumsy to the English reader. The interviews were only interrupted where there was uncertainty as to the meaning of what was being said. For example, when interviewing the transportation planner in Copenhagen, he explained how he contributed to a draft of the Healthy City Plan. During his explanation he stopped short of providing a word to describe how he had felt.

"But I wrote it, what I feel in my heart, this ought to be our policy. It was not opposed to the general plan but it went far further. So I was a little bit ..."

I presumed that he was struggling to find the appropriate English word, and so suggested

"Nervous"?

He then responded:

"No, not nervous but I hadn't foreseen that it would go right through and in to the paper unchanged".

This provided clarification as to the meaning of his previous seemingly unfinished sentence.

The translation of some Dutch and Danish archival data noted in 4.4.8 could also prove to be problematic. There was a possibility of errors in translation because of misunderstanding by the translator. There is also an issue relating to the decoding and encoding in another language by the translator with a capacity to bias original meaning (Fielding and Fielding, 1986). Although the amount of material translated was limited to short extracts, typically a few hundred words from

reports rather than whole texts, there is no way readily available to check against bias. In mitigation, the translators were both native speakers from Denmark and the Netherlands.

4.5.4 Reflexivity

Reflexivity involves a process of self-awareness that should clarify how the researcher's beliefs have been socially constructed and how these have impacted on the interactions and interpretations during the course of the research. My background as a transport campaign researcher working for an environmental pressure group had significantly shaped my perspective, and part of the process of undertaking the study involved me in redefining myself as an academic researcher. This was particularly important during the interview process where interviewees' professional backgrounds, experiences, and views were often significantly different to my own. This meant detaching myself from my background and preconceptions, to 'stand outside looking in' in order to be able to 'hear' their views and preconceptions more clearly, and so inform the analysis, and also to be aware when my own views were beginning to influence the dialogue. This process was not always easily achieved and I found that I needed to be vigilant in order to reinforce this process of self-awareness.

A procedure I applied with regard to the interviews was to spend 5-10 minutes shortly after each interview, making notes as to my impression of how the interview had gone. For example, I noted the strong rapport developed with the Copenhagen Healthy City Coordinator and his active interest in discussing the issues concerning his work on transport. This could be contrasted with my reflections about the interview held with the environmental health officer in the city who, while willing to discuss issues about health and transport was less enthused, having had little opportunity to develop links on this issue. This post-interview process enabled me to reflect on issues such as the degree of rapport established with the interviewee and what influence I may have had on the interview, and as a result of such factors how the quality of the data may have been affected. I also reflected on if, and how, interpretations of issues and specific events

differed between different interviewees, and any particular points raised which were of general relevance. For example, several interviewees gave a clear impression that the links between transport and health were largely those which could be quantified. Such a view differed substantively from my own and this was an occasion when it was important to think through what influence their view would have in relation to collaboration on transport and health.

4.5.5 Rigour

All research methods have their strengths and weaknesses. Being aware of the difficulties and limitations in research design, data collection and analysis are important when undertaking qualitative research and must be addressed by the researcher when designing the research. As discussed above, it is particularly important in qualitative research to produce a plausible and coherent account of the social phenomena being studied (Mays and Pope, 1995).

Consistency was maintained during the process of gathering data by ensuring that each interviewee was asked the same type of question while allowing for specific issues pertinent to both interviewee and interviewer to be explored. Consistency is important in enabling comparisons to be made in the case studies. To illustrate how this was achieved, the first four questions from interviews in each country are set out below, as listed on my itinerary sheet for interviews with both health and transport professionals.

Interviewee: Senior Registrar in Public Health, Sheffield Health Authority

Q. Can you say something about your role in the Health Authority?

Q. Does your work involve you in intersectoral collaboration? If so, with whom and what issues?

Q. How do you view the structures of government departments and agencies in influencing the ability to facilitate intersectoral collaboration in promoting health in Sheffield?

Q. You have mentioned that you have been involved in writing a section on transport in the annual Director of Public Health's report. Can you say something about this?

Interviewee: Transport Planner, Groningen City Council

Q. Can you say something about your role in the Department of Town Planning, Traffic, Transport and Economic Affairs? What are you responsible for?

Q. Does your work involve you in collaborating with people from other sectors? If so, with whom and on what issue?

Q. How do the structures of government in Groningen affect such collaboration?

Q. What do you see as the impacts of transport on health?

Interviewee: Healthy Cities Coordinator, Copenhagen Healthy Cities project

Q. Can you say something about your role as Healthy Cities Coordinator?

Q. In developing the Healthy Cities project in Copenhagen in what ways have the structures of Danish government and associated organisations affected your work?

Q. Different organisations and professions may have a variety of agenda, how does Healthy Cities approach this?

Q. Can you tell me something about the Healthy City Plan and the aspects relating to transport?

While the questions above are largely similar to ensure consistency, a flexible structure meant that the order of some questions changed, reflecting the specific type of work undertaken by interviewees, and new information gained during the course of the fieldwork. The interviewee's responses themselves often raised additional questions so that these were explored before returning to the core set of questions listed on the interview itinerary sheet. In some cases, through discussion of the first few questions, interviewees raised specific issues which were

listed as later questions so that this affected the order of questions. For example, while discussing what the main health issues in the Netherlands were, the National Healthy Cities Coordinator identified the Collective Prevention Act. This was the subject of a later question on my interview itinerary but as it had been raised during the course of discussion it was important not to be prescriptive and interrupt the natural flow of the discussion. An interview itinerary sheet is provided in Figure 4.1 as an illustration of the range of questions asked.

Figure 4.1 Example of an Interview itinerary sheet - Healthy City Coordinator, Groningen City Council

Q. I would first like to ask you about the work of the Groningen Healthy City project. Can you say something about this?

Q. Can you tell me something about the structures in Municipal government and how departments collaborate to promote health? I understand that the Public Health Service is part of the municipal government structure.

Q. Can I ask what, if any effects, the 1990 Collective Prevention Act has had on the work of health promotion in Groningen?

Q. With reference to intersectoral collaboration how do you attempt to convince other sectors (or municipal departments) that health is of relevance to their work?

Q. Has the project helped to change the way some sectors view health? If so, in what ways?

Q. Can I ask you to tell me specifically about any intersectoral collaboration on transport and health?

Q. When I interviewed the Copenhagen Healthy Cities project coordinator he said that because Denmark had maintained a welfare society health promotion is part of the thinking, that is, that there is a general understanding that health promotion provides a public benefit. Do you feel that this is also true for The Netherlands?

There are risks associated with the use of interviews as a research method. Not least is the assumption that interviewee responses will be related to the 'truth' as understood by the interviewee. So there is an issue of trust by the researcher of the researched (Finch, 1993). As discussed earlier, there is a need for researchers to be able to identify with their subjects' perspective but there can be barriers to this occurring. Interviewees may feel the need to be protective or put on a defensive front for their area of work and only a few layers 'beneath' this front may be revealed during the course of an interview so that a public account is given rather than the personal views of the interviewee. Interviewees may also provide accounts which they believe are what the interviewer wishes to hear (Grbich, 1999). The potential for these can be reduced by developing rapport with the interviewee, and through triangulation, both discussed above. There can also be problems where data from different methods do not concur (Bryman, 1992). Again, triangulation is important in confirming or questioning the different accounts. For example, where English health sector interviewee accounts concurred that national policy had not been particularly supportive in helping to further Health for All, this gives weight to claims made in the literature that government Health for All policy is more rhetoric than reality in contrast to contrary claims made in archival sources.

A charge of weakness in the methodological approach could be made in terms of the number of key actors interviewed in each country. While there are logistical limitations in international studies in terms of access to key actors, this was largely not the case in this study. One gap in the interview schedule might have been the lack of inclusion of an environmental health officer in

the Groningen case study, key actors located in this department being interviewed in both Copenhagen and Sheffield. As noted in 4.2.3, however, the snowball sampling technique had identified potential key actors and at no point was the environmental health department in Groningen identified, nor was it highlighted through archival sources.

It is also possible that the study might have been undertaken using alternative methodologies. As noted in 4.3.1, quantitative approaches were rejected because of their rigidity, in not being able to adapt in the light of new data. Combining quantitative data with that of qualitative data, such as through an initial postal questionnaire sent to a larger number of officials in all towns and cities in each of the three countries such as relevant departmental directors, might, however, have been able to highlight some generic issues through which to inform subsequent qualitative approaches, and might also have been able to identify additional key actors for interview. Yet, a pilot study drawing on the snowballing technique worked well in identifying those actively engaged on health and transport issues, generating rich data and then integrating this with archival data. In addition, literature searches and enquiries suggested that the number of staff engaged on health and transport work in municipal government in each of the three countries (and the NHS in England) was relatively small. A questionnaire survey could therefore not be relied on to generate a significant number of responses in order to provide sufficient data with which to make generalisations about transport and health work.

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Chapter 5

The Netherlands Case study

5. Introduction

Rationale

The Netherlands, and the City of Groningen, in particular, have strong policies on road transport and the environment. This chapter investigates how far concerns for health have had an influence on road transport policies, particularly in Groningen. The WHO's Health for All by the Year 2000 was adopted by the Dutch government in 1985 and city-based projects to promote healthy public policies developed across the Netherlands from the late 1980s. In Groningen, the City Council began its Health for All Project in 1992.

Sources

The main sources for this chapter are published policy documents, and interviews. Published document sources are from the Ministry of Welfare, Health and Cultural Affairs, Ministry of Housing, Physical Planning and Environment (VROM), Ministry of Transport, Public Works and Water Management (MVW), and Groningen City Council. The other main source was a series of interviews, held with five key actors/informants. Two of these were located within departments of Groningen City Council. Hermien Bazuin worked in the health promotion division of the Public Health Services Department (GGD) as the Health for All Coordinator, and is responsible for developing intersectoral collaboration including with the municipal department in charge of transport. Cor van der Klaauw worked on road traffic management issues in the Town Planning, Traffic, Transport and Economic Affairs Department. Van der Klaauw's perspective is as someone dealing with transport policy issues on a daily basis. This involves liaising with other departments of the Council which are seen as important in terms of helping to deliver transport policy objectives.

The other three interviewees were all involved with policy at a national level. They each have overviews of Health for All as part of their work but from differing perspectives. Dr Evert Dekker worked in the Ministry of Health, Welfare and Culture in The Hague where he has acted as the National Health Policy Coordinator for ten years and played a central role in drafting policy documents relating to Health for All. Janine Cosijn was the National Health for All Network Coordinator. Based in Eindhoven, she worked for the Public Health Services on implementing Health for All initiatives, and also has responsibility for overseeing the national network of which Groningen City Council is a member. Marleen Goumans was an academic researcher based at the University of Limburg in Maastricht. She is a specialist in Health for All, particularly as a mechanism for policy change. She has undertaken a comparative study of Health for All between five Dutch and five UK towns and cities including Groningen. She is a member of the Unit within the University of Limburg which has undertaken reviews of Healthy Cities for WHO.

Focus

The chapter sets out the findings from primary sources and fieldwork, addressing first the policy context at the national level. It is divided into two parts, the first of which begins with an analysis of the main influences that have shaped the Dutch health promotion and illness prevention policy landscape. These have been the establishment of Health for All policy and targets by the WHO. How these have been incorporated into health promotion and prevention policy both at the national and the local level is explored.

Attention is then turned to transport policy, in which concern for the environment features most prominently. From the mid-1970s, the national government issued a raft of policies on environmental protection and these have been increasingly inter-linked with those on transport as policy has evolved. The policy section concludes by addressing the integration in national policy between transport and health policies. This occurs where there is mutual recognition among the policy makers that there are matters of mutual concern.

The second half of the chapter sets out the findings from a study of the city of Groningen. It begins by providing information concerning the city and the City Councils' structure and organisation. Transport policies and initiatives which have been implemented from the 1970s and which have bolstered the city's standing within the field of European transportation planning are explored, notably the application of a traffic restraint policy.

This is followed by an exploration of Health for All work in Groningen and its influence on transport planning. In this discussion a number of barriers to collaboration were identified by interviewees. This is contrasted with national policy initiatives which have been designed to stimulate health promotion work at the local level. The study of Groningen concludes with a discussion of the drivers of transport policy, in which a concern to protect quality of life in the city is prominent.

5.1 The Netherlands framework for health and transport: an overview

5.1.1 Government structure and organisation

There are three levels of government in the Netherlands: national, provincial and municipal. While subject to some minor amendments, this structure has been in place since the Constitution of 1848, subsequent Provincial Government Act of 1850 and the Municipal Government Act of 1851. The national government and Parliament are located in The Hague where 150 politicians are elected to the Lower House. The country is divided into twelve provinces and each is administered by a Provincial Council with elected politicians whose number varies from 47 to 83. There are approximately six hundred and twenty five municipal authorities, each with a Mayor (Burgomaster) appointed by national government for a period of six years. The municipal council is a representative body. At each level of government politicians are elected every four years (VROM, 1997). By 1995 there were just over 10 million adults registered on the electoral register out of a population of 15.4 million.

The governmental command structure is realised through a 'decentralised unitary state' in which the ultimate source of legitimacy (and finance) is central government, but where precautions are taken to allow for policy-making from below. Over the past few decades there has been a significant shift of power from central government to the provincial and municipal authorities, according to the Ministry of Housing, Physical Planning and Environment (Ministrie van Volkshuisvesting, Ruimtelijke Ordening en Milieuhygiene) (VROM). The aim has been to bring decision making, in terms of accountability, as close to the public as possible (VROM, 1997). Municipalities have a legal right to conduct their own affairs while also having a major responsibility for implementation of nationally agreed policies.

National government is responsible for producing transport and related planning policy, and for producing structure plans for both transport and land use. Regional government is responsible for regional plans, and municipalities for the production of both local structure and land use plans. The function of planning by central government has largely been one of 'steering' and thus identifying how physical planning should integrate with other aspects of public policy (VROM, 1989).

Planning and national policy frameworks for health care and health promotion are controlled by central government through the Ministry of Welfare, Health and Cultural Affairs. However, much of the general responsibility for the delivery of primary care rests with private organisations. General Practitioners are central to primary care as all residents are required to register with a GP and referrals for specialist care are made by GPs. Also important are a range of other professions such as dentists, pharmacists, and district nurses who work largely as private practitioners. Most hospitals are privately owned, usually by church-related organisations, while home nursing is provided by the National Cross, which is a not-for-profit organisation. (Eindhoven

Healthy City Project, 1994). Municipal level Public Health Services (GGD) provide some health care services such as health surveillance and health promotion.

5.2 Policies for prevention and health promotion

5.2.1 International health policy influences

A range of international health policy developments has had some significant influence on Dutch health policy. Not least of these has been the adoption of European Health for All policy in 1980 and of the 38 European health policy targets in 1985 by the Member States of the WHO European Region (See Chapter 3). Member States have an obligation to implement the agreement although this is not legally binding. The Health for All policy sets out the improvements in the health of Europeans that were expected by the year 2000. The policy has six major themes:

- equity;
- health promotion;
- community participation;
- multi-sectoral (intersectoral) collaboration;
- primary health care;
- international cooperation.

While equity is acknowledged to be a 'central preoccupation', community participation and intersectoral collaboration are seen to be essential characteristics of the sort of health promotion and primary health care which can help to achieve Health for All by the year 2000 (WHO, 1985). The targets, which were revised in 1991, identified specific issues or areas where actions were required to protect or promote health. Of these 38 targets, two specifically refer to transport. Target 11 makes reference to road traffic accidents, and target 19 addresses the impact on environment and health of policies and strategies in sectors such as urban planning, energy, transport, industrial development and transport. In addition, target 2 is focused on health and

quality of life, target 18 addresses the need for multi-sectoral policies, and target 24 addresses human ecology and settlements (WHO, 1991), areas with direct links to transport because of the impact of motor traffic on the natural and built environment.

In addition to (and related to) Health for All, the WHO launched a Healthy Cities project in 1986, with its focus on the need for health-conscious policies beyond the health sector. As noted in Chapter 3, the Healthy Cities project was based on the Health for All targets and principles and is seen by WHO as one of its main vehicles for giving effect to the strategy of Health for All. By the end of the first five year phase of Healthy Cities in 1992, 35 cities were officially signed-up to the project (Tsouros, 1995).

Both initiatives had significant influence on Dutch policies for prevention and health promotion. The acceptance by the Netherlands Government of the Health for All principle and targets meant that the Dutch Health Ministry had to address how health policy could be steered towards meeting the 38 targets. Part of the Member States' obligation involves reporting every three years to the WHO about progress made to achieve the targets (Ministry of Welfare, Health and Cultural Affairs, 1993). While some of the targets were focused on the treatment of ill-health others were more clearly orientated to health promotion, an area which had less prominence in Dutch health policy prior to the WHO initiatives (Dekker, 1994).

5.2.2 National and local health policy responses

Dutch health policy has been oriented towards the treatment of ill-health since the Second World War. In 1992, 9.8% of estimated Gross National Product was spent in the Dutch health care sector (approximately NLG 54.7 billion). Of this 95% was allocated to treatment and care and less than 5% to prevention and health promotion (National Institute of Public Health and Environmental Protection, 1994). The Government has nonetheless sought to stress the importance of illness prevention. This can be seen particularly in government health documents

since the Public Health Memorandum of 1966. In the 1966 Memorandum, change in individual behaviour was viewed as most significant in preventing ill health. This had evolved so that by the mid 1980s individual behaviour was seen as just one means of prevention.

In the 1986 policy document Nota 2000, the Ministry of Health, Welfare and Cultural Affairs set out the Dutch response to the Health for All by the year 2000 strategy (Ministry of Welfare, Health and Cultural Affairs, 1992). The Nota 2000 policy adopted the general policy principles of Health for All and represented a shift in emphasis from health service policy to a more broadly based health policy embracing health promotion, prevention and health protection. The Secretary of State for Health has claimed that the importance of prevention had been widely recognised, in part at least, because of Nota 2000.

“Prevention received enormous emphasis in the 1980s. This was due to the *shift in emphasis from facilities to health, illness and disability* (Policy Document ‘The Year 2000’ [Nota 2000], 1986)’. The new emphasis on the *determinants* of health (eg lifestyle, physical conditions and social conditions) demands a policy response in the form of a strategy for prevention.” (Ministry of Welfare, Health and Cultural Affairs, 1993, p. 10)

In support of its claim to be placing greater emphasis on prevention, the Government enacted the Collective Prevention Act in 1989 (also called the Preventive Measures Act). The Act decentralised health promotion work, placing responsibility for public health increasingly in the hands of the municipal authorities. According to the Secretary of State for Health, this gave prevention measures a substantial boost (Ministry of Welfare, Health and Cultural Affairs, 1993). Henceforth, municipal authorities had to develop local health policy, based on the WHO’s 38 targets for Health for All as part of the development of a strategy of Health for All by the Year 2000. By 1992 the Ministry was able to report that at the local level:

“there is tangible evidence of efforts to flesh out intersectoral policy following the entry into force of the Public Health (Preventive Measures) Act through, for instance, innovations such as the ‘healthy cities’ policy.” (Ministry of Welfare, Health and Cultural Affairs, 1993 p. 23)

The establishment of a Healthy Cities project by WHO also provided a spur to Dutch health promotion at the local level during the late 1980s. Two Dutch cities, Eindhoven and Rotterdam became official WHO Healthy Cities in 1987 and 1991 respectively. Other towns and cities joined the national Health for All Network which was created in 1988, and provided with three-year funding by the Health Ministry. By 1995 some twenty cities were participating in the network along with universities and other research institutes (Goumans, 1992). The Healthy Cities idea was used as a model to design and implement local health policy and also to create healthy public policy at the local level (Eindhoven Healthy City Project, 1994). In addition, in 1994 Health for All was incorporated into the Assembly of Dutch Towns, a national organisation representing Dutch municipal authorities. This meant that municipal government politicians had signed up to working according to Healthy Cities and the Health for All principles (WHO, 1999).

5.3 Transport policy developments

5.3.1 Drivers for national policy change

There have been several major influences on transport policy over the past thirty years. Most prominent has been the concern to take action to reduce the environmental impacts of road transport. Dutch transport policy has been steered increasingly since the late 1960s by public concerns for the environment. Discontent concerning pollution, which earlier had been limited to a small number of concerned citizens, gradually became an issue among a broader constituency of the public. Over time, it has been claimed, the mass media came to play an important role. By the end of the 1960s, at the initiative of a number of concerned media specialists, large-scale

television programmes about environmental pollution were being broadcast. These stimulated further public discussion of environmental issues (VROM, 1983).

At this time well publicised anti-car actions in Amsterdam and other towns and cities took place to highlight the need for greater attention to be given to transport impacts on the environment. Car ownership during the 1960s was beginning to rise sharply. As noted in Chapter 2, The Netherlands is the most densely populated country in Europe. It has 442 persons per square kilometre (the UK has 246 persons per square kilometre). It faces a predicted increase of 45% in personal car use by 2010 compared to 1986 levels (MVW, 1999).

In addition, attempts by municipal governments to clear old housing to make way for new developments, which often included major new roads, led to tenants' action groups demanding renovation and conservation instead. Some of these actions were successful, but most importantly they signalled new ways of thinking about urban planning. This was aided by the 1972-73 oil crisis when car-less Sundays were introduced, and were seen by many people as a relief from an environment degraded by motor traffic (VROM, 1983). As discussed in Chapter 2, this concern about the environment also stems partly from a history of battling with the elements, especially the eroding coastline, and the building of dikes to reclaim and protect coastal land.

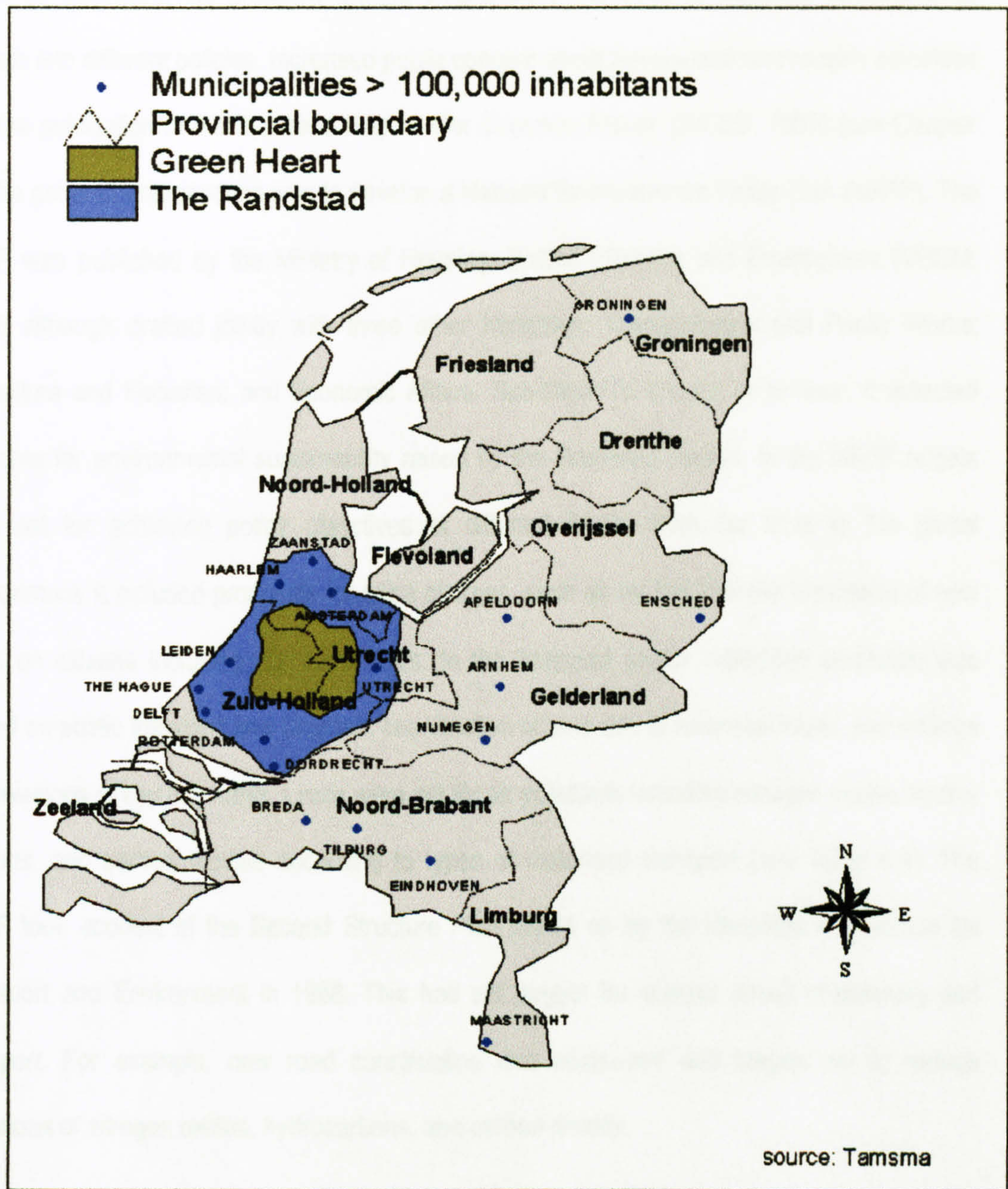
5.3.2 Governmental policy responses

A first response by national government to growing concerns about the environment came in 1972 with the publication of an Environmental Urgency Report. There have been many subsequent reports on transport and environmental planning (see Table I). The Environmental Urgency Report formulated environmental policy by dealing with regional and local environmental problems on a compartmental basis. This meant that discreet departments were responsible for specific tasks (VROM, 1989). For example, environmental health departments were responsible for air pollution issues. There was, however, no structure for intersectoral collaboration on

environmental problems which might span more than one area such as transport even though they could have a significant impact on air quality. The report set in train the development of pollution monitoring and research, the extension of the use of levies on items harmful to the environment such as pesticides, and the encouragement of energy conservation.

Detailed coordination on transport and environmental policies began in 1977. The Ministries of Transport and Environment jointly published the Structure Plan on Traffic and Transport, which attempted to develop a more integrated approach to long-term transport policy. By this time provincial governments were convinced of the need to control the growth of settlements, not least because of the growth in car use with dispersed settlements (VROM, 1983). Part of this integrated approach involved ensuring that new housing developments were located within cycling distance of existing facilities and that the same should apply when designing for new work and recreational facilities. This attempt to control development and keep settlements compact became known as 'compact city' planning. By the early 1980s the concept of the compact city had become firmly established within physical planning and it has been the central idea behind Dutch urban strategy ever since. The aim has been to contain the size of small settlements and concentrate development in existing major centres, while protecting open spaces around the 'green heart' of the Netherlands (Figure 5.1) (Second Chamber of the States-General, 1992). The green heart is an area in the centre of the country which is protected from development, much of which is designated as a national park. The concern to control development, particularly through the compact city and 'controlled dispersal' of population settlements to designated 'growth centres' continued during the 1980s and was reflected in the Fourth Report on Physical Planning, (VROM, 1988). In tandem there was a focus on the development of cities because of population growth and the need for more office locations and business sites in the urban regions.

Figure 5.1 The Netherlands and the Green Heart



A second wave of environmentalism occurred in the late 1980s, partly as a result of concerted action by environmental pressure groups emphasising the need to integrate environmental aspects into different policies. Increased public concern about the environment roughly coincided with the publication of the Brundtland Report 'Our Common Future' (WCED, 1987) (see Chapter 2). The government response was to develop a National Environmental Policy Plan (NEPP). The NEPP was published by the Ministry of Housing, Spatial Planning and Environment (VROM, 1989) although drafted jointly with three other Ministries: Transportation and Public Works; Agriculture and Fisheries; and Economic Affairs. Sub-titled 'To choose or to lose', it reflected concerns for environmental sustainability raised by the Brundtland Report. In the NEPP targets were set for achieving policy objectives at different levels, from the local to the global environment. It included proposals for extra charges, such as on fuel and the imposition of new taxes on citizens including car commuters. In the transport sector increased emphasis was placed on public transport and bicycles, coordination of land use to minimise travel, and ceilings for emissions of key pollutants. Limits were set for air pollutants including nitrogen oxides, hydrocarbons, and carbon dioxide according to types of motorised transport (see Table 5.1). The NEPP took account of the Second Structure Plan drawn up by the Ministries responsible for Transport and Environment in 1988. This had set targets for specific areas of planning and transport. For example, new road construction was postponed and targets set to reduce emissions of nitrogen oxides, hydrocarbons, and carbon dioxide.

Table 5.1

Emission limits for NO_x, C_xH_y (thousand tonnes) and CO₂ (million tonnes) from road traffic

Vehicles	1986	1989/90	1994	2000	2010
	actual	actual	target	target	target
NO_x					
Private	163	-	100	40	40
Goods	122	-	110	72	25
C_xH_y					
Private	136	-	-	35	35
Goods	46	-	-	30	12
CO₂					
Road	23	26.5	26.5	23	20.7

Source: VROM, 1989 (National Environmental Policy Plan)

In 1989 concern about new taxes on commuters led the Liberals within the ruling coalition of the National Parliament to oppose fiscal proposals, which, in turn, led to the resignation of the Christian Democrat government in August 1989. A new national government was elected in September formed by an alliance of the Christian Democrats (still the majority party) and the Labour Party which pledged itself to keeping the environment as a central policy concern. In 1990 the new government sought to hasten the introduction of action to protect the environment through a National Environmental Policy Plan Plus (NEPPP) document.

The NEPP and the NEPPP were central to the strategy for transport for the period 1990-1994. As part of this, seven transport regions were established to provide a coherent policy at the regional level, and act as a mechanism for providing better coordination between central government, the

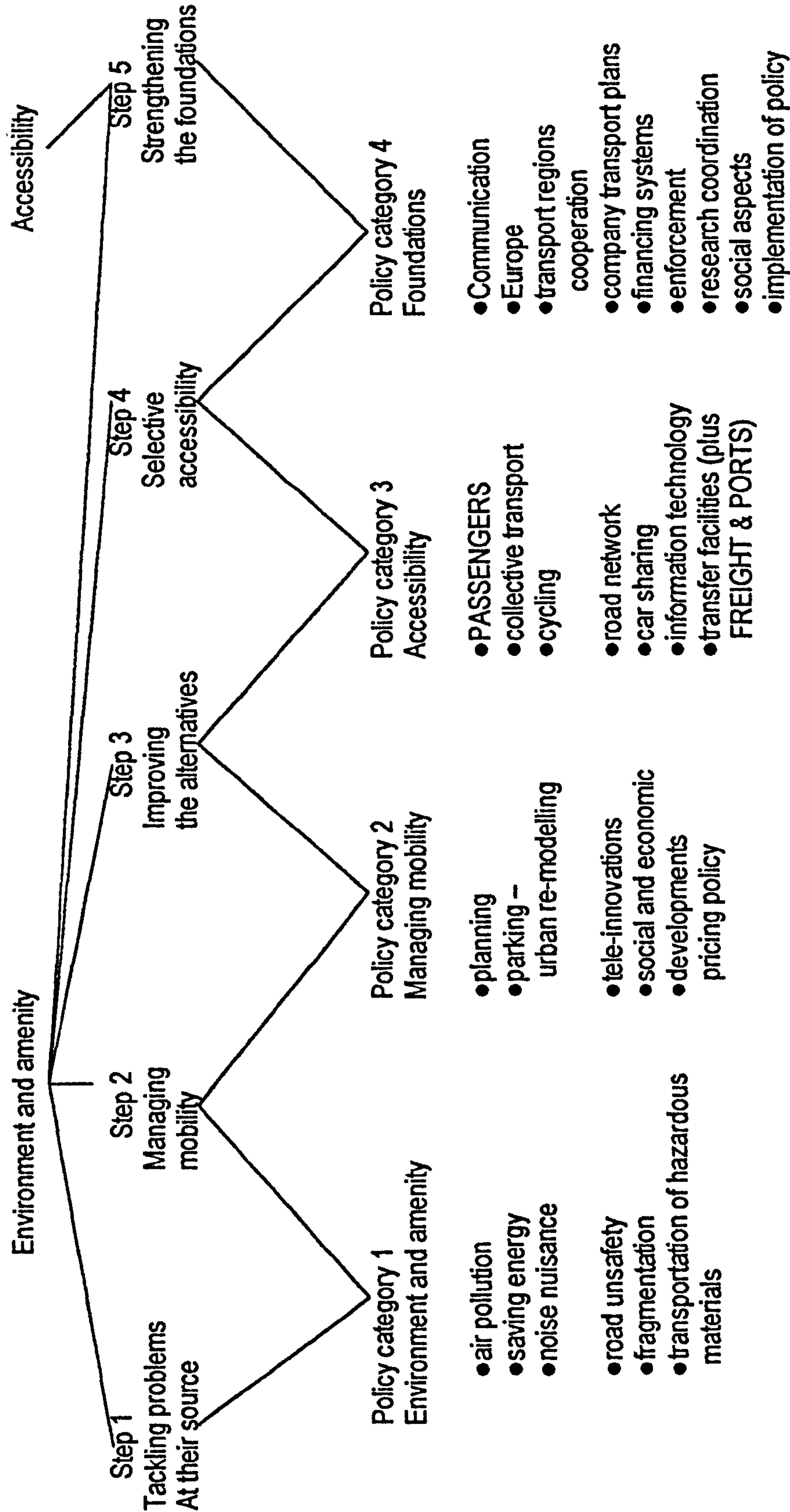
provinces and municipalities. The main functions of the regions embraced local and regional transport, the road network, parking policy, cycle provision, freight transport and integration of transport and landuse policy. The regions developed their own transport plans within the framework of the national policy.

The Second Transport Structure Plan of 1990, which inter-linked with the NEPP and the NEPPP, was mainly concerned with accessibility and quality of life (Figure 5.2). The concept of a sustainable society underpinned the Plan, and this was strongly guided by the concept of sustainable development set out in the Bruntland Report. The Plan identified five steps which the government saw as necessary in order to develop more balance between transport and environmental amenity. These were:

- tackling problems at their source;
- managing and restraining mobility;
- improving the alternatives to the private car;
- selective accessibility on the roads;
- strengthening the foundations with support measures.

It included a target for a 30% increase in rail use by the year 2000 and funds for building the necessary infrastructure. This was followed in 1993 by the Second National Environmental Policy Plan (SNEPP). It provided an evaluation of the NEPP, and sought to provide clear objectives and targets for particular target groups. A particular concern was the continuing difficulty of reducing carbon dioxide emissions and the contribution of freight transport to this. A consultation programme was established as a result to achieve a more fuel efficient and less polluting vehicle fleet. The SNEPP set out the objectives in the context of Agenda 21, the framework for action on the environment for the twenty-first century, developed at the Earth Summit in Rio de Janeiro in 1992.

Figure 5.2 Support Measures for Transport Policy in the Second Transport Structure Plan



Source: MVW, 1990 Second Transport Structure Plan

Table 5.2 Key government reports relating to Dutch Transport and Environment Policy

1972 Environmental Urgency Report

Proposed environmental protection measures for a range of government departments.

1977 Structure Plan on Traffic and Transport

Set out measures targeted at developing a more integrated approach to long-term transport policy than previously.

1987 Second Structure Plan

Addressed the shortcomings of the first Structure Plan which had resulted in uncoordinated and fragmented efforts.

1987 Road Accident Casualty Reduction Plan

Set a number of targets for reducing casualties. The Plan was launched by the Transport Ministry although there was collaboration with the Health Ministry. The overall target was for 50% fewer deaths, and 40% fewer injuries requiring hospital treatment by the year 2010 (from a 1986 baseline).

1988 Fourth Report on Physical Planning

Key concern was the issue of housing location and planning for an estimated million new homes required in the Randstad area of western Netherlands by 2015.

1989 National Environmental Policy Plan (NEPP)

An attempt to develop an environmental strategy fully compatible with the principles of sustainable development. It covered five levels of environment: local, regional, fluvial (river basins and coastal seas), continental, and global.

1990 Second Transport Structure Plan

Mainly concerned with two policy areas: accessibility; and the quality of life. Targets were set to halve the rate of motor traffic growth while increasing the use of alternative modes of transport.

1990 National Environmental Policy Plan Plus (NEPPP)

Largely focused on the need for greater action to promote sustainable development and efforts to accelerate policy measures. The NEPPP required additional action in areas which included carbon dioxide emissions, acid rain, and energy conservation.

1993 Second National Environmental Policy Plan (SNEPP)

provided an evaluation of the NEPP and sought to provide clear objectives and targets for particular target groups.

5.4 Integration between transport and health policy

In some areas of national policy there has been recognition of the links between transport and health and as a result some attempt to integrate policies. Part of the responsibility of the Ministry of Health, Welfare and Cultural Affairs is for accident reduction, which includes road traffic casualties. This had resulted in collaboration with the Ministry of Transport, Public Works and Water Management (MVW) to direct efforts to achieve 'a substantial reduction in accidents involving people killed and injured on the roads' (Ministry of Welfare, Health and Cultural Affairs, 1992). An example of this integration was Health Ministry funding contributions to national road accident reduction programmes such as the area-wide traffic calming pilot project in Eindhoven and Rijswijk which began in 1976 (MVW, 1982).

Asked about the degree of collaboration on transport issues, Evert Dekker, the person responsible for Health for All policy in the Health Ministry, noted that there is a standing intersectoral inter-departmental committee on road safety. But Dekker did not see Health for All as providing a clear mandate for collaboration to address other transport-related concerns.

[Collaboration] "did happen, [although the focus was] not especially in the traffic safety area because I knew that we had a good record and there is a standing intersectoral inter-departmental committee on road safety... on a national level we had this committee and

they have this target. The only health target in the sense of WHO is accidents and that's the [business of the] Ministry of Transport." (Interview with Evert Dekker, National Health Policy Coordinator, October 1995)

There was however, a recognition by the Health Ministry of the threat to health from both air and noise pollution. This had led to particular collaborative working between the Health Ministry and the Ministry of Housing, Planning and Environment. It has been claimed by the Health Ministry that:

"intersectoral policy on health and the environment assumes concrete form in the cooperation between the Ministry of Housing, Planning and Environment and the Ministry of Welfare, Health and Cultural Affairs. Policy which aims to assess the detrimental effects of environmental factors on public health and to prevent harmful effects can be seen in... coordination with other ministries with a view to assessing health effects, where relevant, when taking policy decisions. Examples are noise nuisance caused by air traffic, the smog issue and the indoor environment." (Ministry of Welfare, Health and Cultural Affairs, 1993, p. 27)

The integration of environmental issues into the policies of other sectoral ministries, including health, progressed rapidly during the early 1990s, according to reports from the Ministry of Housing, Planning and Environment. Policy decisions relating to the NEPP are taken by a high level steering committee composed of the Director General or senior representatives from key Ministries (VROM, 1997). Intersectoral agreement on policy goals requires departmental commitment to a range of targets. These are monitored by a government monitoring unit, ensuring that departments themselves have an added incentive to implement change. Hence:

"The Netherlands government has formalised the target group approach into a policy in which environmental problems can be tackled by different actors in society at the most appropriate stage of their operation... Targets send messages to all actors - environment and other government ministries, local government, business or the public - that change is required." (VROM, 1997, p. 8)

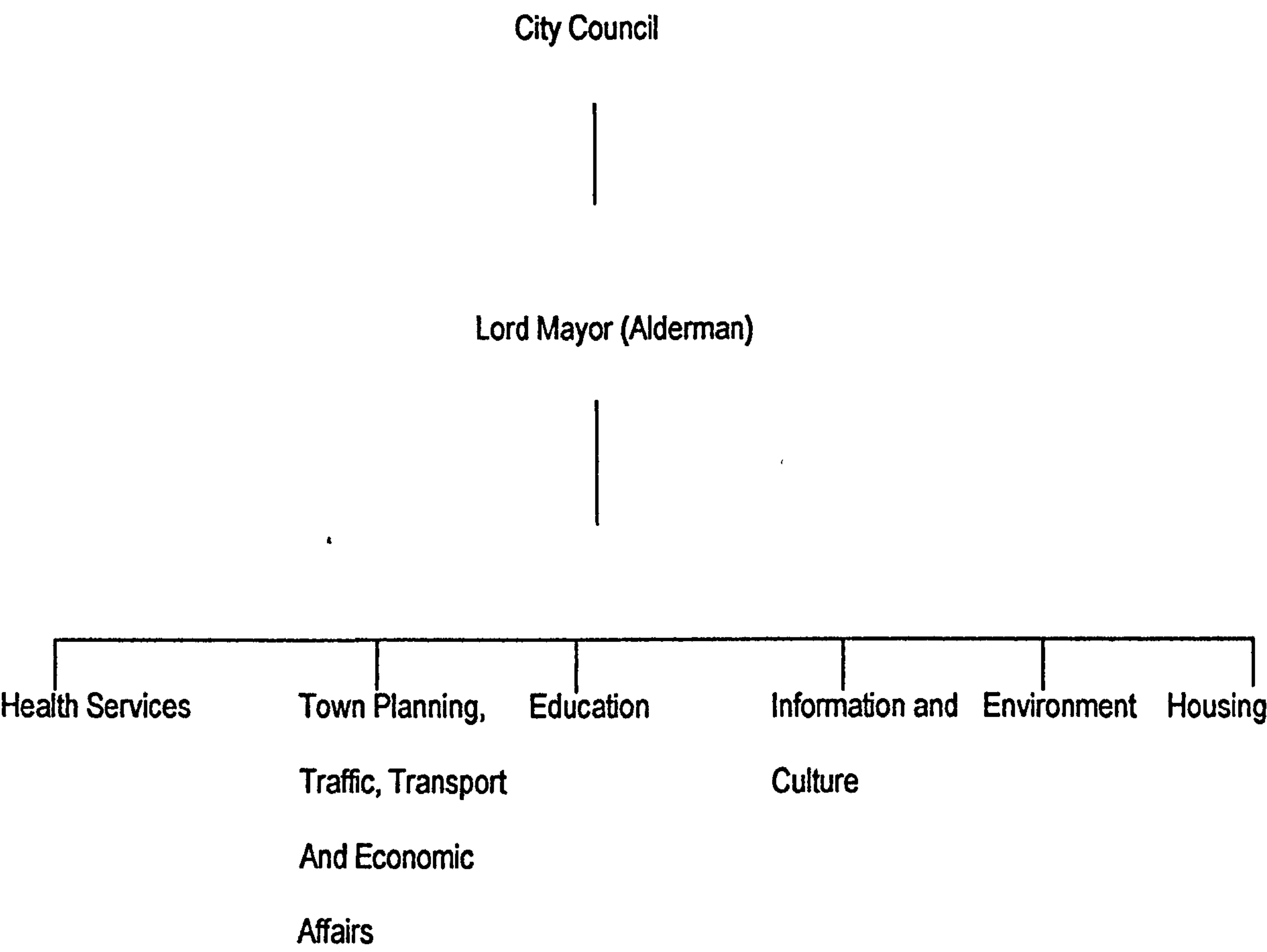
5.5 Groningen

5.5.1 The city

Groningen is the capital city of the province (region) of Groningen and was founded in the middle ages. The city is the sixth largest in the Netherlands, with a population of 170,000. It is in the north of the country in an area with few large towns or cities nearby. Groningen is the main educational and cultural centre of the north of the Netherlands. It acts as the regional centre for employment with a relatively large proportion of its 98,000 jobs being taken by people who live outside the city. It caters for over 25,000 higher education students and each year approximately 6,000 new students come to live in the city in order to begin their studies while a large proportion of those who finish study leave to start employment elsewhere. Because of the role of higher education in the city many of the jobs are in education. Government is also a major employer because Groningen is not only the location for the City Council but also for Provincial government (Groningen City Council, 1995).

Groningen municipality has six departments (Figure 5.3): Health Services (GGD); Town Planning, Traffic, Transport and Economic Affairs; Education; Information and Culture; Environment; and Housing. Each has an elected head, and a Lord Mayor who is not elected but appointed (similar in position to the Chief Executive post found in most UK local authorities). Transport issues are the responsibility of the Town Planning, Traffic, Transport and Economic Affairs Department, while health promotion services reside within the Public Health Services Department (GGD). This municipal government organisational structure is not untypical in the Netherlands.

Figure 5.3 Departmental Structure for the City of Groningen



Source: Groningen City Council, 1995

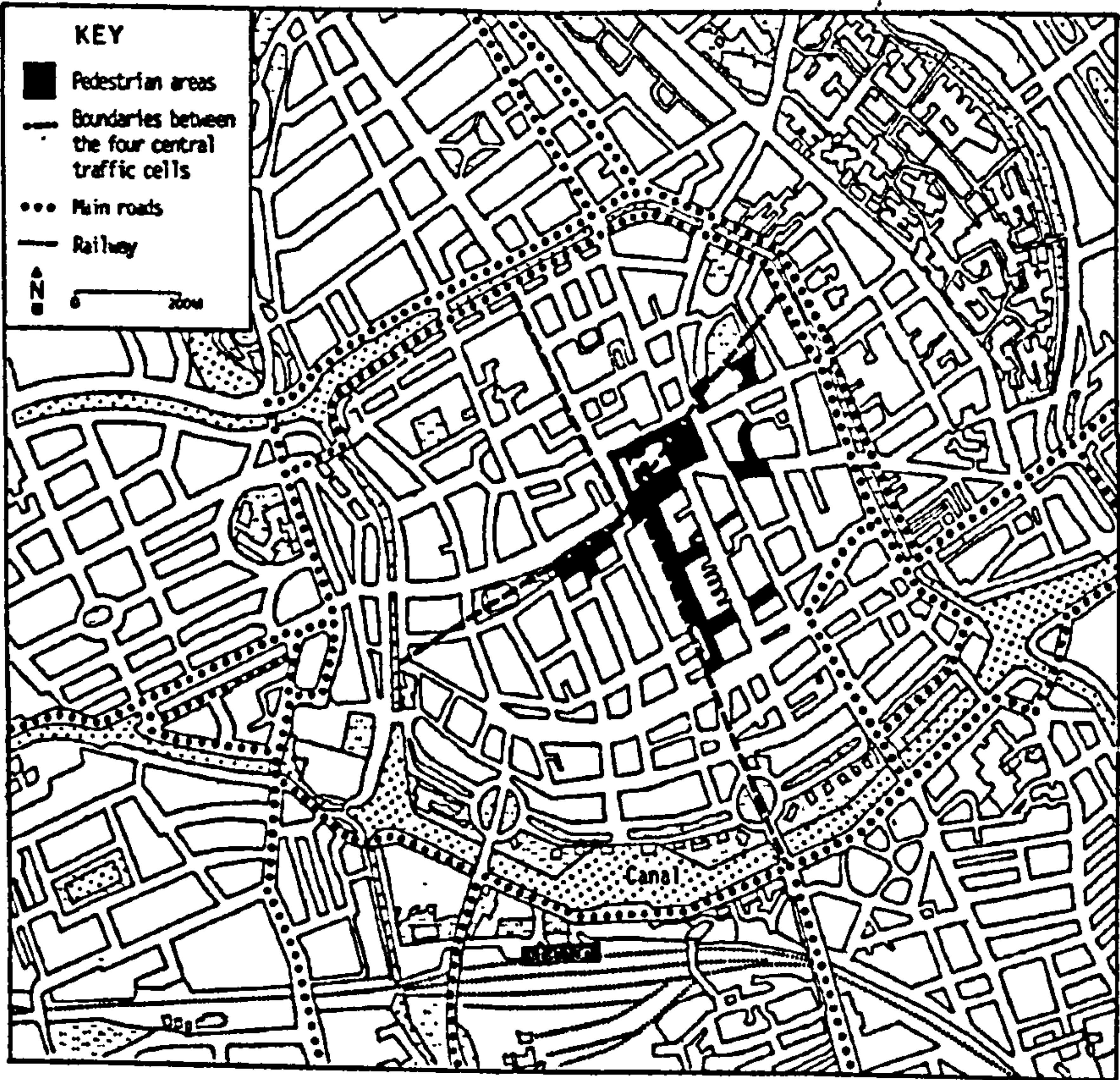
5.5.2 Transport policy initiatives

In recent decades Groningen has gained a reputation for its innovative transportation policies, as noted in Chapter 2, and this informed the choice of case study. Post-world war two the population of the city, especially the inner sectors, was in decline and car commuter traffic was rising. Motor traffic was severely congesting the central area of the city. All through traffic had to pass through the Grotemarket, the central square. This made life particularly unpleasant for pedestrians and cyclists (Groningen City Council, 1985). The municipal response in the 1960s was plans to construct three ring roads and adapt existing roads to better cater for motor cars. Yet just as in other towns and cities in the Netherlands during the late 1960s and early 1970s, there was a public backlash against the dominance of the car and municipal plans for demolition of old inner city housing in Groningen. Tenants' action groups were calling for the renovation of old housing rather than its destruction (VROM, 1983). The Socialist Group which had come to power in 1972 took the opportunity to review priorities in the city, giving much greater consideration to environmental issues than had the previous administration.

A traffic restraint policy was adopted by the ruling Socialist Group and implemented in 1977 through a radical traffic circulation plan following a concept developed in Bremmen, Germany. The inner city was divided into four sectors on a north/south and east/west axis and private motor traffic was prohibited from crossing the sector boundaries through the erection of barrier controls with special bus 'gates' to provide access (Figure 5.4). Access was also provided for bicycles (See Figure 5.5). This improved conditions remarkably for public transport, pedestrians and cyclists, and reduced car density in the city centre (Figure 5.6). In Groningen, as the national government has noted:

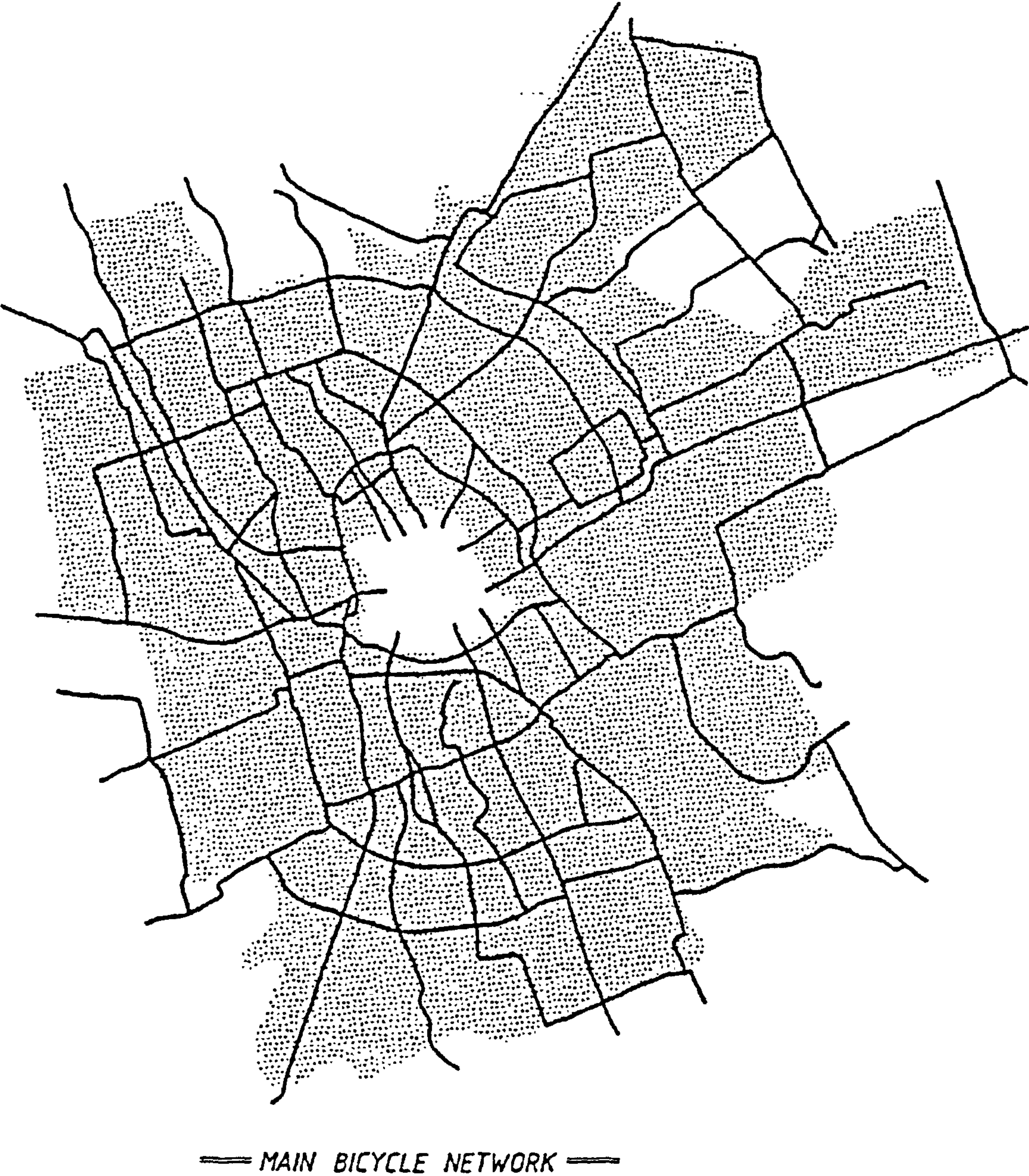
"Government services, cultural functions, social life, recreation and living were put on a par with industrial and shopping functions. This put paid to the effort to make the inner city maximally accessible to private motor traffic." (VROM, 1983, p. 19)

Figure 5.4 Groningen city centre traffic restrictions



Source: TEST, 1989

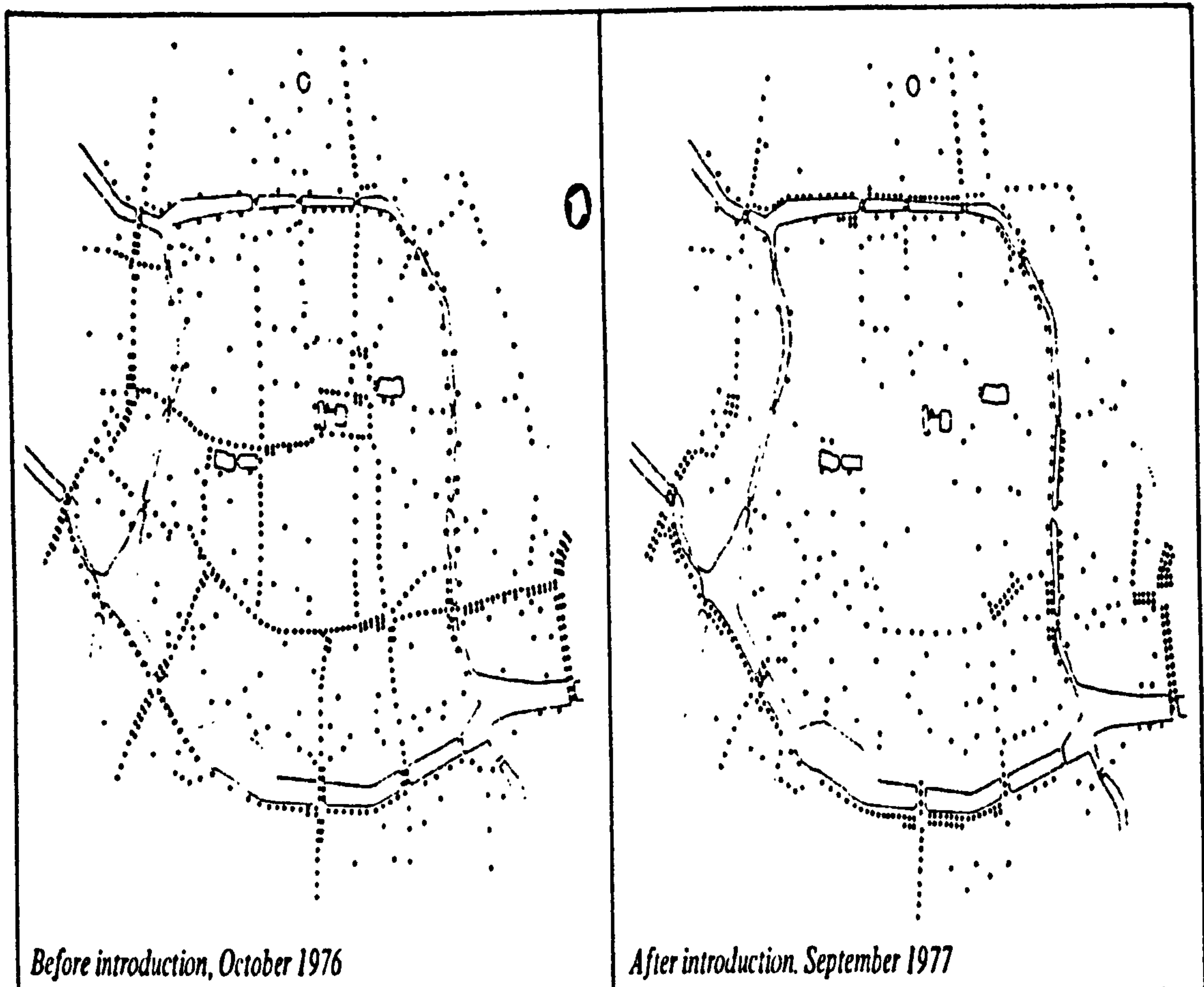
Figure 5.5 The main bicycle network in Groningen



Source: Groningen City Council, 1992

Figure 5.6

Car density in central Groningen before and after the implementation of the Traffic Circulation Plan



The inner city of Groningen. Car density before and after introduction of the traffic circulation plan (sector plan).

By the early 1980s the traffic circulation plan was widely regarded as a success and it has since been positively promoted by central government as a way of improving the quality of life while still providing some limited access to the city centre by motor traffic, notably commercial vehicles. The decision to introduce the traffic circulation plan was made in order to meet the Council's twin goals of economic development and improving quality of life (Groningen City Council, 1985; 1992). As claimed by the City Council:

"Groningen gives priority to the use of public transport and bicycles. Car traffic must be restricted, but in a selective way. Car traffic which is economically necessary, such as for example for delivering goods, will be exempt from restrictive measures. On the other hand, non-essential car traffic, such as commuter traffic, must be curbed." (Groningen City Council, 1992 p. 6)

During the 1990s Groningen gained international recognition within the field of transport planning for the success it had in transport planning, and in particular in promoting cycling (MVW, 1995). One result has been a notable level of general media interest in England in how Groningen achieved its favourable level of cycling and low levels of car use. For example, writing for the Sunday Telegraph in August 1993, Adam Nicholson wrote:

"How has Groningen achieved a level of civilised life which most British cities have not even thought of?... The entire planning system in Groningen is based on the idea of the compact city, so that nowhere is anywhere more than 10 kilometres from anywhere else. Up to that distance the bike will be the obvious first choice." (Nicholson, 1993, p. 13)

5.6 The influence of Health for All on transport planning

5.6.1 Health for All in Groningen

The establishment of a Health for All Project in Groningen in 1992, albeit relatively late considering the establishment of the National Health for All Network in 1988, is evidence of some commitment to national and international policies stressing the importance of health promotion and prevention work (called Healthy Cities by Groningen GGD). As the Coordinator notes, its resourcing means that the Project's work has progressed slower than hoped for.

"Groningen is a Healthy City since 1992 but we have not got a formal structure as ... we haven't got special information so it means that it is not going as fast as we like. I am the

one person in this organisation that is responsible for the Healthy City being.” (Interview with Hermien Bazuin, Health for All Coordinator, October 1995)

The Groningen Health for All Project has placed particular focus on reducing smoking, alcohol, illegal drug use, and mental health. It has also sought to understand the relationship between some of these health problems with less economically affluent groups in the population. This has meant addressing health issues in particular districts of the city. Work has also been targeted on the causes behind some of these problems. There is a recognition that campaigns which have targeted just one form of health damaging behaviour are probably less successful than those aimed at ‘hidden problems’ (Groningen City Council, 1994).

5.6.2 Health for All and transport planning

A key issue for this study is to explore the extent to which Health for All has been successful in exerting influence on transport planning. The Health for All Coordinator certainly made attempts to develop projects with staff in other departments of Groningen City Council. The Project was relatively new in Groningen, and by time of the interview in October 1995, often only exploratory meetings with officials from other departments had taken place. Such meetings had not been particularly fruitful, according to Bazuin, in that there was a lack of political commitment to Healthy Cities amongst some politicians. For example, having been to the Environment Department to see what work could be undertaken together on the theme of the Healthy City, Bazuin noted that the outcome was not particularly successful. Lack of political commitment was cited as a barrier to progress.

“The first round [of talks with departments] didn’t get very many results, it was just too abstract and we have now got a better position and we try to initiate a broader project with the Economic Development and Transport Department. The political commitment is not already there for the Project in this specific area. We would like to start a project together

She reported that in terms of the WHO Health for All transport-related targets, the work of Health for All in Groningen had no identifiable influence. Intersectoral policy work did not include collaboration with staff working on transport issues.

5.6.3 The influence of the Collective Prevention Act

Health for All was not seen by respondents to have had much impact on transport planning. In a similar way, the 1989 Collective Prevention Act stimulated little new thinking or action. The Act was legislated to stimulate health promotion work at the local level and, as was noted earlier (5.2.2), the Health Ministry claimed 'evidence of efforts to flesh out intersectoral policy'. The Act was important because it provided a legal basis for Health for All work. In Groningen, however, it appeared to have essentially confirmed work which had already been going on and did not open up transport to Health for All influences. Bazuin commented:

[The Act] "is the basis for the tasks of our health department now. It also says something about cooperation with other sectors in the cities, which is the basis for our work. So it has had a lot of impact on health promotion. It is the legal basis. The impact is not radical, things have not changed all that much after implementation of that Act because it was a confirmation of an existing situation and existing development." (Interview with Hermien Bazuin, October 1995)

There was consensus among the health sector interviewees that health promotion work could only progress in areas of the municipal government where there was political support for it. In transport that support was lacking. This was evidenced by the lack of any mention of the importance of health in the Council's transport policy reports (Groningen City Council 1992; 1995). Cosijn, the National Health for All Network Coordinator, stated that getting the support of the politicians was critical to whether or not different departments in the city councils sought to address health promotion issues.

"In practice, of course, as now every city council is responsible they can make their own decisions, [to do] what they want. It [the Act] creates more responsibility for the City Council but it is also an extra burden for them. The problem is then for us to convince the politicians." (Interview with Janine Cosijn, October 1995)

In particular, and in contrast to the Health Ministry's claim, the Act was seen by the health sector interviewees as having little effect in stimulating more intersectoral collaboration on health issues. The Act did, however, provide some support to Public Health Services Departments wanting to place greater emphasis on health promotion. Marleen Goumans, the academic researcher, commented:

"What it did do, it gave the Public Health Services Department a tool to go to the local authority and say that 'you ought to do something about...' The other thing is that the City Councils realised very much that people could point at them and say 'you have to take your responsibilities'. So, in that sense, it is a tool for going to people, but in terms of content, from my outside perspective, I don't see that they are doing anything else or new, or in a different way due to this law." (Interview with Marleen Goumans, October 1995)

Evert Dekker from the Ministry of Health cited government-funded research indicating that although there had been more work on health promotion since the Act came into force health promotion was still largely seen as a matter for the senior management of the health department. The intersectoral aspect of Health for All was not being achieved.

[The Collective Prevention Act] "had improved in terms of more health promotion. On the other hand [the research] showed that local politicians didn't promote more intersectoral collaboration. It is still a matter of the Director or his or her management which decides on

health policy." (Interview with Evert Dekker, National Health Policy Coordinator, October 1995)

5.6.4 Barriers to Health for All influencing transport

Particular barriers inhibited the ability of Health for All in Groningen to influence transport work. The interviewees discussed both officer and political resistance, especially from departments which traditionally have few links with Health Services. Goumans noted that the Directors of the Public Health Services Department complained that in meetings with other departments it was only their staff who raised issues about health. This was despite the incorporation of Health for All into the Assembly of Dutch Towns organisation.

"The Directors of the Public Health Services Department said to me 'it is not anyone else but only me who is saying 'but what does it mean for health and shouldn't we look towards health'." (Interview with Marleen Goumans, October 1995)

Evert Dekker, from the Ministry of Health, who had overseen national policy work on Health for All for over a decade put forward a reason for the lack of interest in collaboration with the Public Health Services Department. Dekker stated that politicians tended to conceptualise health as ill-health so that health promotion and preventive measures became marginalised.

"Health is not really an important issue, that is the point. Because most people, if they talk of health, they talk in terms of diseases. Do you know our Alderman? He is the elected responsible board member, you can say, he or she when they ask about health it is always about hospitals and talk with general practitioners about care and health services." (Interview with Evert Dekker, October 1995)

Hermien Bazuin commented that the departments tended to work separately, and political concerns driving policies in other departments were not seen to fit well with those of Health for All.

"We want to work together with departments in the city but sometimes it is not possible for practical reasons and sometime because politicians have missions and ideas other than the health ones. We have also tried to cooperate with other departments and met with lots of trouble [difficulties]." (Interview with Hermien Bazuin, October 1995)

The National Health for All Network Coordinator, Janine Cosijn, thought that some departments were easier to establish working relationships with than others. Intersectoral collaboration was most easily established with those departments which she perceived as being 'very close to the Public Health Services Department', such as the welfare and education departments, where there was a tradition of collaboration. Cosijn did not view this to be the case with departments which have responsibility for environmental and traffic issues. Here, there are few, if any, previous working links. So while it might be relatively easy for an individual officer to collaborate with colleagues in another department, Cosijn thought that it was not just individual perspectives that were important but also professional perspectives about whether collaboration with particular professions was accepted practice. This could determine whether collaboration was sought, as well as what type of response was forthcoming from the staff in other departments.

"We manage to do that [collaborate] with departments which are very close to ours, welfare, education, and so on. It is very difficult to talk to engineers [and for them to accept] that they also have their responsibility for health. But even when you talk to people from the environment department, and when you talk about Local Agenda 21, and we say that there is a clear link with Healthy Cities it is [still] difficult." (Interview with Janine Cosijn, October 1995)

This is reflected in Goumans' comments that for those involved in Health for All it was difficult to link transport to concerns beyond environmental health and road safety. These were usually raised in discussions with healthy cities staff only after a range of other environment-related issues had first been listed.

"Transport was not the first mentioned in relation to healthy cities. It was always the environmental health thing and then safety and greening aspect of the city, housing, and transport was mentioned in terms of safety, or related with air pollution." (Interview with Marleen Goumans, October 1995)

When asked about health links with transport, van der Klaauw also mentioned pollution issues. He highlighted those staff in the Environment Department dealing with environmental health issues such as air quality and noise pollution. Such staff could provide him with information about pollution effects of road transport. But he did not identify staff working in the Public Health Services Department as collaborators who could likewise provide useful information for his work.

"There is contact with people from the environmental health department. Not only the people who collect rubbish but more the people who will bring in the environmental aspects in the different policies. Especially air quality, and also with noise. That's the main health aspects of transportation." (Interview with Cor van der Klaauw, Transport Planner, October, 1995)

5.7 Drivers of transport planning policy

5.7.1 Environmental and economic influences on transport planning policy

Previous sections have reported how the Health for All officer sought to engage with transport staff and explored barriers to collaboration. The Transport Planner discussed what he saw as the

driving forces behind transport planning policy in Groningen. Central to these were economic development and quality of life. Through the implementation of the 1978 traffic circulation plan Groningen's politicians had sought to pursue a balance between quality of life and economic development. Van der Klaauw connected quality of life with transport in broad terms. Transport had negative effects in terms of a general degradation of the physical environment, and specifically through air pollution, but also positive effects in that transport could enable access to social networks.

"I think it [quality of life] is an aspect which a lot of things are involved with. It is not only noise, it is not only air pollution but it also means that you have the possibility of coming out of your house, like this old lady, going to the bingo or church or meet other people from their own age and that they also have the possibility of coming out of the house and going to the city centre to do some shopping." (Interview with Cor van der Klaauw, October 1995)

Van de Klaauw also saw quality of life as meaning that people have freedom from dependence on others. In this respect too, the transportation system is seen to be very important. This he related to issues of social inclusion and exclusion, noting that besides a Physical Structure Plan there was also a Social Structure Plan which placed particular emphasis on quality of life (Groningen City Council, 1995). He stated that people needed to be able to maintain social networks irrespective of whether they had an income. Quality of life encompassed having enough resources to ensure that individuals were not excluded. This includes the ability to travel to gain access to services, facilities and people:

"quality of life means that everybody doesn't have to be that dependent on others. That they are more independent. The transportation system is a very important aspect of quality of life. It is also that you have enough money to go to the sports or people who don't have enough money, you help them by giving them a special pass so they can go to the

swimming pool or the library in a cheaper way... So quality of life is not only an aspect of environment and transportation, but also the social integration in the whole town."
(Interview with Cor van der Klaauw, October 1995)

When asked about quality of life, Bazuin also raised the issues of social inclusion and exclusion, and the Physical Structure and Social Structure Plans. She commented that the Social Structure Plan provided an opportunity for Health for All in Groningen to contribute because social cohesion was an important theme across the Council's work.

"Most of the differences in the health situation are related to the economic situation so that's an aspect where we collaborate with other departments to improve the social structure of the city, of different parts of the city and to do something about unemployment." (Interview with Hermien Bazuin, October 1995)

Goumans was mindful of the connotations which the label 'Healthy Cities' imposed on those projects. The word 'health' could too easily pigeon-hole Healthy Cities into a narrow interpretation that health is just concerned with the treatment of people who are ill and not about promoting good health through policy actions in areas beyond the health sector. She thought that 'quality of life' could convey better Health for All aims than Healthy Cities and that a more environmental 'label' still meant doing the same type of work.

"Often, it appears that you can better use any other word than health due to, I guess two reasons. One is that although health can be everything but also nothing, people still conceive health to be not ill, a doctor or a hospital. Second is, therefore, that it is very difficult to understand or to see what this has to do with health... In the end the label healthy cities will end any way and may be we should not include health any more? And, of course you have this European Community Ecological Cities, and Sustainable Cities, but

actually what you are doing is all the same." (Interview with Marleen Goumans, October 1995)

Concerns about quality of life in Groningen were strongly related by van der Klaauw to controlling car access and providing alternatives, but this had to be balanced with the needs for economic development. This meant that there could be tensions between these two central goals of Groningen City Council. He recognised this in his own area of work.

"The economic development of the town is very important for the town planning. That means coming by car ... without any congestion is very very important. So, sometimes that gives a bit of tension between the environmental aspects and economic affairs." (Interview with Cor van der Klaauw, October, 1995)

In 1993 a new policy initiative 'Hand on heart, a new city centre for Groningen' (Groningen City Council, 1993) set out to further advance the twin policy aims of economic development and quality of life. In this programme the municipal authority stated that there were three inter-related topics which required attention: accessibility; the selection of shops; and the social climate. The basic assumption was that accessibility by modes other than the car were priorities.

"Good accessibility is essential for the economic functioning of the city centre. The city centre is predominantly the domain of the pedestrians and cyclists and it should become more attractive to these groups while other traffic participants should adjust their behaviour. Also, the use of public transport should make car traffic less essential." (Groningen City Council, 1993)

In the autumn of 1995 the tensions between environment and economic considerations, according to van der Klaauw, were reflected in debates in the local papers about bus lanes into

the city centre. Because bus services were every fifteen minutes the bus lanes were used for only a small amount of time. Some people thought that they should be made available to general commuter traffic.

"We have some bus lanes, especially on these roads here where the bus has got absolute priority and because of the frequency here is just every fifteen minutes... it gives a lot of discussion in the papers about giving more room to the cars. Because sometimes there is congestion between here and here and there is no bus on the bus lane." (Interview with Cor van der Klaauw, October, 1995)

5.7.2 Collaboration in support of transport policy

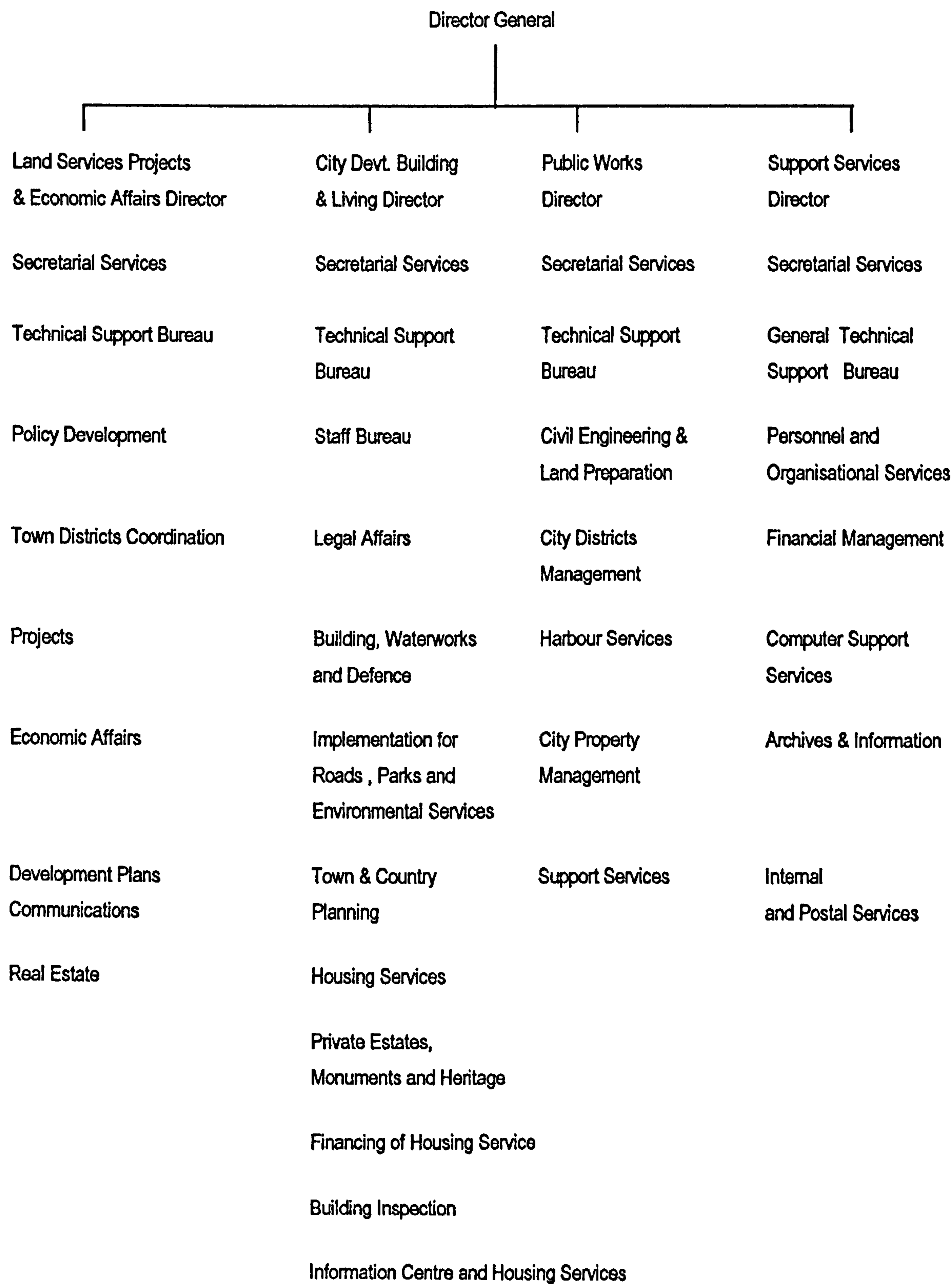
The previous section discussed the importance of quality of life and economic development in transport policy. This section identifies the range of collaborators in support of the transport policy, and this indicates that some other departments perceived these policies as important to their own policy goals, such as the Environment Department. Those collaborating had left out Health for All because it was not an issue on their agendas. The Transport Planner identified the departments with whom he collaborated in order to carry out his work. Van de Klaauw noted that transport planning cannot operate in isolation from the work undertaken in other policy areas. He listed a variety of people outside his department with whom he collaborated. The nature of his work meant that he had to collaborate with public transport operators as well as with colleagues from other parts of the municipality. Collaborating with other officers where he felt they were of relevance to his work was not difficult. He noted that his department had a high level of contact with the Environment Department, and the Department of Information and Administration, besides transport operators. Moreover, because the Department of Town Planning, Traffic, Transport and Economic Affairs, is responsible for a broad range of policies (Figure 5.7), he was often engaged in intra-departmental and multi-disciplinary team working. Collaboration did not, however, include health promotion staff.

Van der Klaauw illustrated the importance of intra-departmental and multi-disciplinary team working through a number of examples. Firstly, he described the importance of planning public transport services to take account of the needs of elderly residents in a new housing area in the city. His department dealt with housing as well as transport issues, including plans for starter homes and homes for the elderly, so when designing new residential streets he could readily collaborate with colleagues with responsibility for planning new housing developments.

"The part of the department which is to do with housing, they make the plans for starters and old people. So it is very important to have contact with these [housing development planners] because in a new area when you plan a bus route you have to plan so that the pensioners are near to the bus stops." (Interview with Cor van der Klaauw, October 1995)

It appeared that transport work in Groningen was being integrated with other policy areas relating to the environment. In some cases the process was further encouraged through intra-departmental work on projects, such as in the example of where new housing was being built. The identification of the Environment Department as a regular collaborator suggests that environment and transport policies were seen by officers in both policy areas as linked, as they have been in national policies. Additionally, the goal of quality of life was viewed by the transport officer as not only relating to the need to place restrictions on private motor transport but also positively in terms of transport enabling access for people.

Figure 5.7 The Structure of the Department of Town Planning, Traffic, Transport and Economic Affairs



Source: Groningen City Council, 1995

Van der Klaauw also gave the example of transport's coordinating role in providing access to services for children who are disabled and how his department worked particularly with the Education Department in order to do this.

"For children coming to special schools or coming to swimming pools the Department of Education has made a special contract with the bus company. What we do now is to bring all these different contracts, and also the money - to coordinate. We have contact with people from education, from the health department for disabled people. So I think that is an example of coming together to see what you can do for each other." (Interview with Cor van der Klaauw, October 1995)

In contrast, the health sector interviewees found little by way of examples to illustrate how links were being made between health and transport. Bazuin and Cosijn were not able to provide examples. Goumans referred to a national project on road accident reduction involving the Transport and Health Ministries but nothing at the local level. Dekker, from the Health Ministry, having worked for ten years overseeing Health for All work at the national level, could only cite collaboration on road accident reduction initiatives. This was the one area where he identified collaboration in support of transport planning and which made a link to Health for All policy.

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Chapter 6

The Danish case study

6. Introduction

Rationale

Copenhagen is one of the few cities in Europe where car use has declined in the past twenty years. This is the result of strong transport and environment policies at both the city and national government level. This chapter explores what influence, if any, the Copenhagen Healthy City Project has had on the City Council's transport policies since its establishment in 1988.

Sources

Some of the main sources for this chapter are published documents from the Ministry of Environment and Energy, Ministry of Health, Ministry of Transport, Copenhagen Health Services, City Roads Department, and Lord Mayors' Department. The other evidence is drawn from interviews held with four officers from departments of Copenhagen City Council. Bjarne Eir was the head of Traffic Planning in the Roads Department. He had worked in this department and in the Planning Section of the Lord Mayor's Department for most of his professional career. Raymond Skaarup was an environmental health officer, and the head of the Air Quality Division within the Environment Agency of the City Council. He was responsible for the monitoring of air pollution. Jens Egsgaard was the Healthy City Coordinator for Copenhagen, based in the Health Services Department. He had previously worked as a hospital administrator. Ann Rindel was an epidemiologist working for the Medical Office of Copenhagen and had undertaken studies of the effects of air pollution on health. The Medical Office is the statutory body in Copenhagen responsible for disease prevention and health promotion. It has some statutory powers. An additional interviewee was Kit Broholm, the Healthy Cities Network Coordinator for Denmark. She was based within the Danish Board for Health in Copenhagen.

Focus

The chapter discusses the findings from the primary sources and fieldwork. Divided into two parts, it first addresses national policies, beginning with those on disease prevention and health promotion before considering transport policy developments. It notes the influence of international health policy, in particular Health for All and a set of associated targets. Denmark's health promotion policy has been influenced by Health for All.

In the field of transport policy, there is a similarity with the Netherlands in that environmental and transport policies have been increasingly inter-linked since the 1970s. The section notes a number of traffic policies designed to control car ownership and use, and the development of targets to further limit the impact of motorised transport on the environment. There has been some collaboration between the transport and health sectors in order to address policy areas of mutual concern.

The second half of the chapter sets out the findings from the study of Copenhagen. It begins by detailing the planning principle which has underpinned transport policy since the drafting of a plan for controlled development along public transport corridors. This was the 1948 'Fingers Plan', which was incorporated into subsequent Regional Plans for Copenhagen.

Following on from this is an exploration of the Healthy City Projects' influence on transport planning in Copenhagen. Two initiatives of the Health City Project are described which, according to interviewees, were of particular significance to the City Council's Roads Department. These were the completion, in 1991, of a city-wide Health Profile of the population, the first of its kind in Copenhagen, and the drafting of a Healthy City Plan in 1992-93. The section then explores a range of influences on transport and health collaboration which were identified by interviewees: organisational; political; and cultural.

The case study concludes by identifying what the drivers of transport policy have been in Copenhagen. Interviewees note how the Roads Department has capitalised on the favourable levels of cycling and public transport use and low car use, which have been linked to the absence of major road building in recent decades. It is suggested that this stable traffic situation has provided firm foundations for more innovative approaches to transport planning policy.

6.1 The framework for health and transport work in Denmark

6.1.1 Government structure and organisation

Denmark has been a constitutional monarchy since 1849. Under the present constitution, adopted on 5th June 1953, legislative power is exercised jointly by the monarch and an elected single-chamber Parliament known as the Folketing. There are 179 members of the Folketing. The number of people registered to vote is 3.5 million. There are three tiers of government in Denmark: national, county and municipal, with elections at all tiers of government taking place every four years (Economist Intelligence Unit, 1996).

National government is responsible for environmental protection and the development of national standards. Once established, the municipal and county councils are responsible for meeting these standards. The principle is that, within the framework set by national government, local communities should be able to determine the level of environmental quality that is acceptable or desirable and take responsibility locally for the costs and choices necessary to achieve it (Ministry of Environment and Energy, 1995). National government is also responsible for producing transport and related planning policy. This includes the production of national transport plans. Transport planning takes place at the county and municipal tiers as well, although such planning must comply with the national plans. At the county level, 'Regional Plans' are produced every twelve years and revised every four years. The 1994 Planning Act requires that counties and municipalities include provision for, among other things, traffic facilities and transport services when preparing their land use plans.

Planning and national policy frameworks for health care treatment and health promotion are controlled by central government through the Ministry of Health. However, much of the general responsibility for health care rests with the County Councils. This is the most important of their functions and includes treatment, curative medicine, primary health care, and health promotion. Health care accounts for roughly 75% of county budgets (Ministry of Environment and Energy, 1995). Municipalities are responsible for home nursing and a number of disease preventive programmes, school health and dental services. In health care, as in other areas, municipal and county councils are free to determine the quality and quantity of their services within the limits and obligations set by legislation. Most health service providers in Denmark are salaried public employees working in institutions owned by the state (OECD, 1994).

The 14 County Councils perform a strategic function in terms of developing County Plans, and for coordination within each county area, such as for health care treatment, and land use planning. There was some re-organisation of county government in 1989 when the Greater Copenhagen Council was abolished and replaced by three new counties. As a result of this restructuring, the municipalities of Copenhagen and Frederiksberg were given County status in addition to their municipal government responsibilities (City of Copenhagen, 1991).

Since 1970, after major reform of municipal government, local autonomy has been significantly strengthened and greater responsibility placed with municipal government for the delivery of more services and tasks. The majority of services are controlled by municipal government which directly controls over 35% of all public expenditure. Financing is mainly by local taxation (Andersen, 1993; Ministry of Environment and Energy, 1995).

A key principle is that most local decisions do not require approval by higher authority. Framework legislation has been a focus for much of central government work since 1970. A

series of statutes set out which decisions are delegated to lower tiers of government. In Danish law, the municipalities are regarded as independent units whose freedom of action, like that of individuals, is protected by the rule of law. This means that central authorities may exercise the powers of a superior authority only to the extent authorised by statute (Jensen, 1984). According to the Ministry of Environment and Energy, Denmark has one of the most decentralised governmental systems in the world.

"Denmark delegates more public sector tasks to its two levels of local government, municipal councils and county councils than in any other country in Europe." (Ministry of Environment and Energy, 1995, p. 4)

The Danish social welfare system, the foundations of which were laid in the 1920s and 1930s, is structured around universal welfare (Swedish National Board of Health, 1993). Originally with an emphasis on redistribution to benefit the most socially and economically disadvantaged, the welfare system developed to improve, amongst other things, the provision of schooling, health care, social services, old age pensions, irrespective of economic status (WHO, 1980). Decentralisation to municipal authorities has given them greater financial responsibility for, and financing of, health care (OECD, 1994). The most important task of the 275 municipalities is to provide social welfare services, and preventative programmes such as immunisation. Health services, including hospitals, reside largely within the municipal authority's remit. Welfare services include means-tested welfare benefits, sickness benefits, disability and housing pension and housing benefit. Municipal government is also responsible for primary and lower secondary school education, maintaining the local road network and utility supplies such as gas, electricity and water, and for a range of environmental services including air pollution monitoring and waste disposal (Ministry of Environment and Energy, 1995).

6.2 Policies for disease prevention and health promotion

6.2.1 International health policy influences

Like the Netherlands, Denmark has been influenced by international health policy developments and particularly by the European Health for All policy (1980) and the 38 European health policy targets (1985). Denmark adopted these, along with other Member States of the World Health Organisation (WHO). The targets, which were revised in 1991, identified specific issues or areas where actions were required to protect or promote health. As noted in Chapter 5, two targets specifically refer to transport, while others are directly and indirectly linked to transport because of the impact of motor traffic on the natural and built environment.

As in the Netherlands, the establishment of the WHO Healthy Cities project in 1986 provided inspiration for Danish towns and cities as a means through which the Health for All policy could be implemented locally. Some Danish municipalities began to develop Health for All initiatives from the late 1980s irrespective of whether they became official WHO Healthy Cities projects.

6.2.2 National and local health policy responses

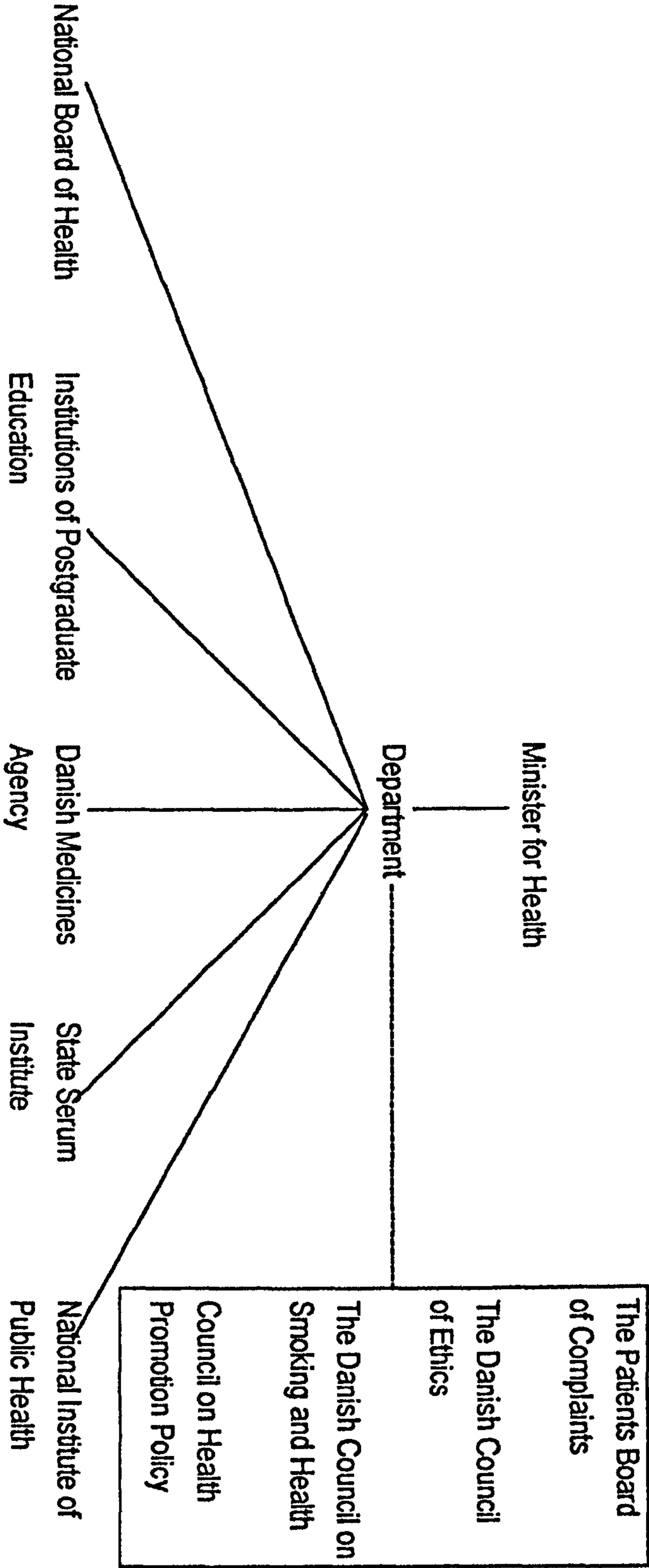
Health care in Denmark has been oriented towards the treatment of ill-health since the Second World War. In 1995, roughly 6% of Gross National Product was spent on health care (Ministry of Health, 2000). The organisational structure of the Danish Health Service is set out in Figure 6.1. Health promotion, through the work of health promotion staff had, until the 1980s, played a limited role in Danish health policy. There was, until 1994, no statutory requirement for county and municipal authorities to undertake health promotion work. As noted by Kit Broholm, National Healthy Cities Network Coordinator:

"in a county you have... a health promotion person who is dealing with everything, accidents or whatever, one person. It is up to that person who hasn't got any special Masters degree on health promotion but who can be a social worker or a health nurse or

something like that. It is up to her or him, mostly her, what she is interested in. So therefore health promotion isn't that well rooted in Denmark." (Interview with Kit Broholm, July 1995)

In 1988, the City of Copenhagen and the town of Horsens were successful in their applications to WHO to become Denmark's official WHO designated Healthy Cities. As in other countries, the enthusiasm of city authorities to become involved in the implementation of Health for All policy led to the establishment of a national network. Promoted particularly by Copenhagen and Horsens, a National Healthy Cities Network was launched in 1991 by the Minister of Health who presented one million kroner to support the Network (Healthy City Project, 1994a). By autumn 1995, 9 municipalities and 6 counties were members of the National Healthy Cities Network. Established as a binding network, this meant that there had to be political support within each town or city for participation in the work (Healthy City Project, 1994a). It has a secretariat provided by the National Board of Health and employs a Coordinator. The Network has aimed to provide support to individuals working at the local level in helping them work on health promotion with the range of municipal government departments. It was based in Copenhagen until 1997.

Figure 6.1 The organisational structure of the Danish Ministry of Health



Source: Ministry of Health, 2000

Health promotion was given a higher priority in Denmark from the late 1980s. This was due to the recognition of the fact that many of the determinants of ill health are social (lifestyle factors such as alcohol consumption, smoking, and lack of exercise) (Ministry of Health, 2000). The Ministry of Health was inspired by the WHO, and particularly projects related to the Health for All by the Year 2000 strategy. A health promotion programme was established in 1989, the first of its kind in Denmark. This placed increased emphasis on efforts to promote health beyond the health sector with the associated need for intersectoral collaboration between health promoters and other professions. The Ministry of Health prepared the health programme in collaboration with eleven other ministries (including Transport), with particular attention being paid to creating healthier lifestyles in the population (Healthy City Project 1994a). The programme was adapted from the WHO Health for All by the Year 2000 strategy (Ministry of Health, 2000).

As part of the health programme, in 1992 the Danish Parliament introduced changes into the Public Health Insurance Act so that from January 1st 1994 planning for health promotion became the statutory responsibility of the counties and municipalities. Counties are required to establish plans for the organisation of work on disease prevention and health promotion as well as describe the health status of the population. Municipalities have to develop plans every four years for health promotion and disease prevention measures. The Act does not stipulate what the Plan must contain but just that there has to be a Plan. The Act has provided a framework for action at the municipal level (Healthy City Project, 1994a).

6.3 Transport policy developments

6.3.1 Drivers of national policy change

Concern for the environment has been notable since the 1960s when it was first taken up as an issue by student groups. As discussed in Chapter 2, Denmark is particularly dependent on its natural resources for jobs and wealth creation. Denmark's relatively recent industrialisation and the continued strong position of its agrarian sector within the economy throughout the twentieth

century (Landes, 1969) is also a factor in concern for the environment. Nearly 80% of the land is used for agriculture and forestry and only 5% is urbanised although this is where 85% of the population lives (Ministry of Environment and Energy, 1995). During the 1980s, opinion polls indicated that environmental protection was perceived by the public as being the most important political priority (Jamison et al, 1990).

During the 1960s, pollution was becoming an issue of concern, concerns being voiced both by students groups and by new environmental pressure groups. Most notable was the environmental campaign group NOAH which was given a weekly column in the largest Danish daily newspaper, *Politiken*, in 1968. The more conservative and largest environmental organisation in the country, the Danish Conservation Society, voiced its views on pollution through the publication of its own reports in 1970 and 1971 which warned of the consequences of pollution - both environmental and political. Environmental groups were particularly successful in raising a critical consciousness by exposing pollution problems, the lack of government action, and the need for pollution control measures. The oil crisis between 1972-74 provided further pressure for measures to reduce demand for fossil fuel (Ministry of Transport, 1993b).

The energy crisis was the catalyst for the introduction of 'car-free Sundays' during the winter of 1973-74 (TEST, 1989). The energy crisis and growing environmental awareness led to some people switching from cars to bicycle and public transport, and subsequently to increased demands for improved conditions for cyclists in particular (Ministry of Transport, 1993b). Cycling has a long tradition in Denmark and particularly in Copenhagen. Despite the rise of car ownership and use from the 1950s, cycling maintained a strong presence with one third of adults using bicycles regularly even at the lowest point in cycle use at the beginning of the 1970s. The tradition of cycling is explained, in part at least, according to the Ministry of Environment and Energy, by the fact that a high proportion of the Danish population live in cities where distances, such as between home and work, are relatively short (Ministry of Environment and Energy,

1995). The tradition is also related to the provision of dedicated cycle paths, including during periods of rapid growth in motorisation in the 1950 and 1960s (Ministry of Transport, 1993b).

During the 1980s, catastrophes such as Bhopal, and Chernobyl, and the effects of acid rain, ensured that environmental issues occupied a prominent position in political debate. By the late 1980s, environmental pressure group activity centred on questioning the effectiveness of the environmental protection systems which had been established by government rather than a lack of action (Jamison et al, 1990).

6.3.2 Government policy initiatives

The national government began to play an important role in environmental issues from the early 1970s. This was in large part a response to increasing awareness of the need to address pollution issues and the lobbying by environmental pressure groups. In 1969 a governmental board had collected data in an attempt to map the pollution situation in Denmark. In 1971 the newly elected social democratic government created a Ministry for Environmental Protection and in 1973 passed an Environmental Protection Act (Jensen, 1984). NOAH helped in the drafting of the legislation. Part of the Act introduced control mechanisms through which to promote land use planning based on the protection of natural resources and the separation of residential from industrial areas. Furthermore, it laid the foundation for coordination of this development within the general framework of economic development, both on a local and on a national basis (WHO, 1980).

Throughout the 1970s the state increased its environmental protection initiatives, establishing special divisions and research units for numerous environmental topics and employing a large staff of legal advisers and technical experts to develop a more coherent and effective governmental environmental policy (Jamison et al, 1990). This included the establishment of the Danish Road Directorate which was given responsibility for, among other issues, environmental

research with regards to road transport. It should be noted that despite extensive searches, little archival data from the Ministry of Transport was found. As Tengstrom (1999) has noted, Danish transport research was very limited until the 1980s, and this may partly explain the paucity of data. This claim is supported by other Danish transport researchers (Holvad, 2001).

In order to protect pedestrians and cyclists and improve the environment, the government passed a number of Acts of Parliament to control motor traffic speed. A 1976 Road Traffic Act to protect children travelling to and from school gave the police and municipalities responsibility for providing safe routes to school. Section 3, article 3 of the Act states that:

"it is the responsibility of the police and the road administration, upon consultation with the schools, to make provisions for the protection of children, against the dangers of the wheeled traffic, on their way to and from school." (quoted in Nielsen, 1990, p. 255).

Further changes in traffic law, through the Road Traffic Acts of 1978 and 1983 provided for the redesign of the highway, allowing municipalities to introduce 15kph and 30kph zones. These were implemented widely across Denmark in the following years (Russell, 1986). Research by the Road Directorate reported a 78% reduction in serious injuries as a result of such schemes (Engel and Thomsen, 1992).

In 1982 the Danish Parliament also passed a Municipal Planning Act. This distinguished between three main types of traffic: motor traffic; light road users (eg pedestrians and cyclists); and public transport. The Act stipulated that when a municipal traffic structure is planned, the traffic networks for each of these three types should be defined (Road Directorate, 1993). In addition, all highways budgets should have a budget heading for cycle track construction in order that the amount of money spent on cycling facilities could more easily be identified (Ministry of Transport, 1993). The Ministry of Environment and Energy operates a 'Traffic and Environment Fund' which

supports municipal authorities with proposals for redesigning streets such as for parking control, noise abatement, and pedestrianisation.

The publication of the Bruntland Report 'Our Common Future', in 1987, provided an added incentive for action on environmental issues by the national government. A direct response was the adoption of a comprehensive national action plan for environment and development in 1988. Entitled 'Our Shared Future', it set out how Denmark would steer policy towards sustainable development. This was followed by a number of action plans in various sectors including transport. The Transport Action Plan of 1990 set targets for reducing the environmental damage caused by transport, and outlined expected development in the transport sector up to 2030 (see Table 6.1).

In 1993 a new Plan, 'Traffic 2005' was published by the Ministry of Transport. This had new predictions for traffic growth in Denmark and set out five strategies for an efficient and flexible transport infrastructure. The plan sought to locate Denmark within a wider European context in terms of the Single Market but retained the focus of the 1990 Plan on reductions in pollution. In addition, the government set a target of a 60% reduction in nitrogen oxides and hydrocarbon discharges by 2030 and also targets for reduction in noise. The plan defined five strategies to achieve these objectives:

- the volume of traffic and transport and mode;
- promoting alternatives to car transport;
- curbing environmental problems;
- influencing setting new priorities for traffic investment;
- improving traffic planning and research.

The main conclusion of the White Paper was that a European Union transport policy should address environmental considerations specifically (Ministry of Transport, 1993a).

The commitment to sustainable development is illustrated by the fact that Denmark is one of the few countries where the principle of sustainable development is enshrined in law. For example, Section 1 of the 1994 Planning Act states that:

"This Act shall ensure that the overall planning synthesises the interests of society with respect to land use and contributes to protecting the country's nature and environment, so that sustainable development of society with respect for people's living conditions and for the conservation of wildlife and vegetation is secured." (1994 Planning Act)

The development of transport and environmental planning policy in Denmark has not been particularly influenced by pressures from commercial interests in road transport as Denmark does not have a domestic car manufacturing industry. In the 1960s, the Danish government was able to impose a high excise tax on cars being imported since it is in Denmark's economic interest to do so (Russell and Pharoah, 1989). Together with a relatively comprehensive public transport network and a tradition of, and provision for cycling, the high costs of car purchase may have meant that many people did not feel the need to buy a car. This is the view of the government, which has stated that:

"relatively high excise taxes on cars in Denmark has been one factor in keeping the number of cars per capita relatively low despite a high per capita income." (Ministry of Environment and Energy, 1995, p. 13)

The Ministry of Transport has stated its intention to maintain the high taxes on car purchase as a means of regulating transport demand (Ministry of Transport, 1993a).

Table 6.1 Key government reports relating to Danish Transport and Environment policy

1988 Our Shared Future

A response to the Brundtland Report, it set out how Denmark would steer policy towards sustainable development.

1990 Transport Action Plan

This set a target of stabilising carbon dioxide emissions at the 1988 level by the year 2005, to be followed by a 25% reduction up to the year 2030. It also set targets for reducing nitrous oxides, hydrocarbons, particulates, and noise levels in terms of the number of homes subjected to more than 65 dB(A).

1991 The State of the Environment report

This publication focused on the environment as a whole, providing an assessment of conditions and threats to environmental resources.

1992 National Planning Report - Denmark towards the year 2018

The report provided a vision for Denmark's spatial development in the future of Europe. It included goals for the development of towns and cities in Denmark, the overall transport system, rural districts and tourism.

1993 Traffic 2005

Traffic 2005 was prepared in the light of the forecast that passenger transport was expected to increase by almost 25% by 2005, and goods transport by 40%. The energy and environmental objectives of the 1990 Transport Action Plan were re-stated.

6.4 Integration between transport and health policy

There is recognition of some of the links between transport and health in national government policies. As in the Netherlands, the actions have been focused around road traffic casualties and motor traffic pollution. In 1986 the Danish Road Safety Commission was established, consisting of Members of Parliament, representatives from the county and municipal authorities (which included the health services), police and non-governmental organisations. In 1988, the

Commission produced its first National Road Safety Action Plan which sought to achieve the goal of a 40% reduction in the number of traffic casualties by the year 2000 compared with 1988 (Ministry of Transport, 1993a). The Ministry of Transport continues to collaborate with the Ministry for Health on achieving traffic casualty reductions. The Danish Road Safety Council acts as the coordinating body for traffic safety and receives funding from both the Ministry of Health as well as from the Ministry of Transport.

The Ministry of Health has developed a public health programme which seeks actions across all government departments. For the Ministry of Transport this focuses on 'healthy environments', where air and noise pollution are to be minimised by increased efforts to promote alternative forms of transport to the car, particularly cycling. The strategy for transport states that 'healthy traffic must be integrated into working life'. In the programme there is a strong emphasis on protecting 'weaker traffic users' through a range of prevention measures from 'information, control, research and monitoring' (Ministry of Health, 1999 p. 87).

6.5 Copenhagen

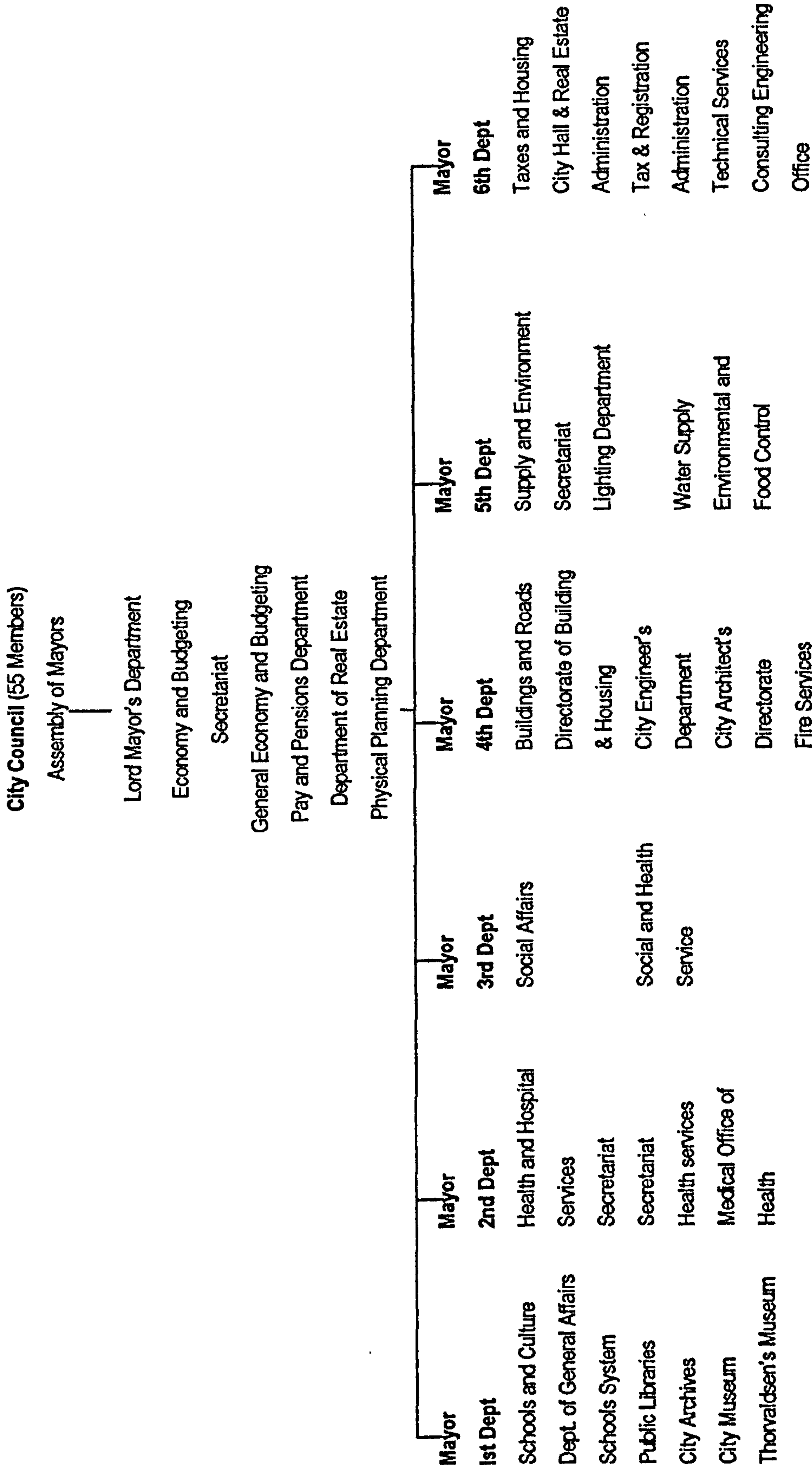
6.5.1 The city

Copenhagen, the capital city of Denmark, lies within the region of Greater Copenhagen and on the eastern edge of Denmark's most easterly island. Greater Copenhagen contains one third of the Danish population and this has been increasing since the 1950s. In contrast, in 1950 the City of Copenhagen had a population of 768,100 but this had fallen to about 465,000 by the mid 1990s (Copenhagen Statistical Office, 1995). This population loss has been especially from inner districts with more affluent families moving to the suburbs due to a combination of factors including deteriorating housing stock and environmental quality. It has been noted that this population decline has been concomitant with the growth in car ownership (TEST, 1989).

The Lord Mayor is head of the Council and has the power of veto over six Mayors who each head a department and are elected into office. The Lord Mayor and Mayors are seven of the fifty-five members of the City Council. The members represent residents in fourteen districts. The Lord Mayor heads a department with overall responsibility for the economy and budgeting. The six other departments are; Schools and Culture (1st Department); Health and Hospital Services (2nd Department); Social Affairs (3rd Department); Buildings and Roads (4th Department); Supply and Environment (5th Department); Taxes and Housing (6th Department). This is set out in Figure 6.2.

Figure 6.2

Administrative structure of the City of Copenhagen



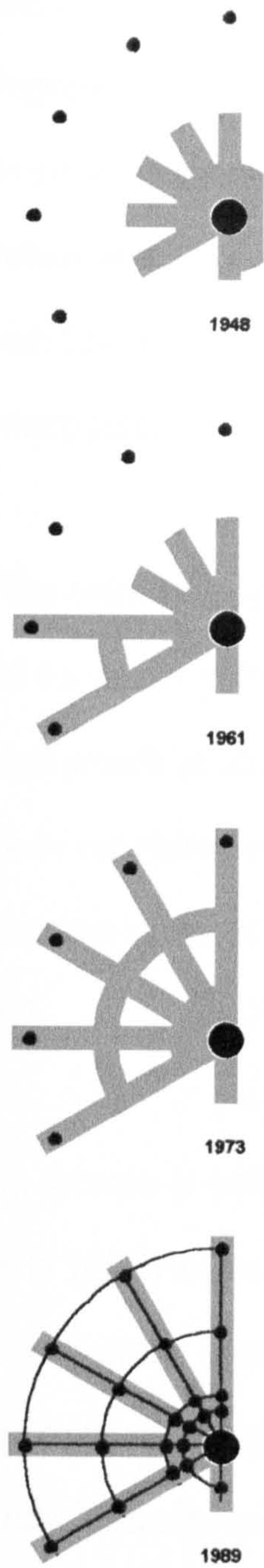
Source: City of Copenhagen, 1994

6.5.2 Transport and planning policy initiatives

While car traffic growth in Greater Copenhagen beyond the City of Copenhagen has continued to grow since the 1950s, in the City itself a range of traffic restraint measures has led to a different situation. This informed the choice of case study. Since 1979 car ownership in the city has declined slightly during the 1980s and has remained largely stable into the 1990s. One in five households in Copenhagen owned a car by 1996. This is half the level of the rest of Denmark, and Denmark has fewer cars than its neighbouring countries (City of Copenhagen, 1996).

Observations of the effects of high levels of car ownership in the United States and some other European cities led a group of Danish planners to develop an integrated planning and transport policy for the City of Copenhagen in the 1940s (TEST, 1989). This became known as the Fingers Plan principle, with development focused along key public transport served corridors or 'fingers'. The Plan was developed by the Danish Town Planning Institute, accepted by the government and embodied in a 1949 Planning Act. Generally, Regional Plans since 1948 (1961, 1973, 1989, and 1991) have continued to steer development in a planned manner along the public transport corridors (Figure 6.3), although this was undermined significantly in the 1950s and 1960s through rapid growth in car ownership which tripled in the city. In this climate, plans for new railway lines were replaced by those for road construction (Ministry of Environment and Energy, 1995).

Figure 6.3 Copenhagen's Fingers Plan development



Source: Copenhagen Municipal Plan, 1993

As congestion worsened during the 1960s, however, plans for a new rail system were raised again and eventually some new lines were built after the passing of legislation. An aspect of the 1973 Regional Plan was to link the fingers by encouraging businesses which did not need to locate in the centre to establish at suburban centres where the orbital bus routes intersected with radial railway lines (City of Copenhagen, 1991). The Plan has continued to be updated and is linked with City Council Plans. The 1991 Municipal Plan for Copenhagen, for example, proposed that planning policy should be public transport orientated.

"The entire traffic system shall easily and swiftly, using the least possible resources, cover all the various traffic requirements of citizens and industries. The public transport system shall provide an attractive means of transportation for people who cannot or do not wish to go by car. Particularly in the densely-populated city areas the competitiveness of the public transport system is important for environmental reasons." (City of Copenhagen, 1991, p. 17)

An early success in traffic restraint was the pedestrianisation of the main shopping street, Strøget, in 1962. This led to a 35% increase in pedestrians on the street in the first few years and the 'evaporation' of 62% of motor traffic from surrounding streets. This meant that motorists had been discouraged in large numbers from driving to the centre while pedestrian volumes rose significantly. Pedestrianisation was later extended to include some of the other surrounding streets. In the early 1970s some city centre areas were then closed off to private motor traffic and simultaneously new parking controls were introduced. At the same time, traffic calming schemes were also introduced in large areas of the city to reduce accidents. Such measures helped to positively change public attitudes favourably towards restraint (Eir, 1994; City of Copenhagen, 1996). The city is also very compact, and the bicycle has been a popular means of transport for many decades, providing a positive cultural climate for further promotion of cycling. In the summer months, 30% of journeys in Copenhagen are made by bicycle (Eir, 1994).

6.6 The influence of the Health City Project on transport planning

6.6.1 Healthy Cities in Copenhagen

The main task of Copenhagen's Health Services Department is to promote health, provide for the examination and treatment of patients, and to supply nursing and care (Healthy City Project, 1994a). As the City has county as well as municipal status it is responsible for most health services, including health promotion.

An additional impetus to health promotion work in the city came when Copenhagen was designated as a WHO Healthy City in June 1988. In order to achieve the overall goal of Health for All, the Copenhagen Healthy City Project recognised that health promotion and disease prevention had to have a significantly more prominent role than previously in the work of the municipal authority (Healthy City Project, 1994a). For this reason it was decided by the municipal government that the WHO Healthy Cities project provided an appropriate vehicle for the development of health promotion in Copenhagen with a distinct programme of projects to achieve this.

"In the case of Copenhagen we believe that this aim [Health For All] may be best achieved through concrete projects which will improve citizen's health." (Healthy City Project, 1994b, p. 2)

Designation of the City as a 'Healthy City' required the establishment of a project, the appointment of a project officer, an agreement to fulfill certain commitments such as to establish mechanisms to secure community participation in health promotion, and the development of a Healthy City Plan within a set timescale.

The Government's stance towards health promotion made the task of establishing a Healthy City Project in Copenhagen easier than it otherwise might have been, according to Jens Egsgaard, the Healthy City Coordinator.

"It has definitely made it easier because the move towards health promotion since the mid-'80s, it has taken a positive shift. Where that positive shift has come from is sometimes difficult to set out in detail. But the Government has facilitated this process by making a commitment to health promotion." (Interview with Jens Egsgaard, July 1995)

Egsgaard thought that the tradition of social democracy in Denmark enabled health promotion programmes to be implemented with more ease than perhaps in non-social democratic countries. He noted that in Denmark compromise was common practice in politics whereas in Britain this was less the case.

"If you look at it on more historical lines I think in some ways health promotion should be inherent in the thinking of the welfare society. It should be there. It is there, it is a part. Scandinavian societies are welfare societies which makes it much easier for health promotion. If you look at the British scene, in society, among parties, [there is] a political system which always creates a majority situation. We are use to compromise. I think that that plays a role also for health promotion..." (Interview with Jens Egsgaard, Healthy City Coordinator, July 1995)

6.6.2 Healthy Cities and transport planning

A key part of the investigation was of the extent to which Health for All had been successful in exerting influence on transport planning. This section discusses two initiatives of the Health City Project, both required as part of the agreed actions the municipal authority signed up to on becoming a WHO Health City Project. Both initiatives identified transport as having an important

impact on health. The first was a city-wide Health Profile where more than 12,000 responses were received to a questionnaire which asked about how people perceived their own health. Such a Health Profile had not previously been undertaken. A specific Health Profile was drawn up for each of the fourteen districts, as well as one for the elderly, one for children, and one for the city overall. These indicated that people in Copenhagen perceived that their health was poorer than for those living elsewhere in Denmark (Healthy City Project, 1994b). Copenhagen citizens were also found to have weaker social support networks than Danes elsewhere (Healthy City Project, 1994a).

The Health Profile produced data regarding the public's perceptions about the impact of traffic on their health. The Profile results suggested that the public were concerned that their health and quality of life were being undermined by, among other things, 'too much traffic'. In some districts well over half of the residents said that they felt exposed to air pollution from traffic, notably in those districts in around the city centre. For example, in the district of Inner Nørrebro, when asked 'what can the 'local authorities do?' over 50% of respondents said that they wanted the local authorities to take action to reduce the problems caused by the traffic. This was the most frequent single proposal. Types of initiatives proposed were those which would reduce the danger, noise, and air pollution from traffic.

"In particular, the people in Inner Nørrebro want the local authorities to contribute to reducing inconveniences caused by the traffic...[they want] initiatives that reduce danger, noise and air pollution from the traffic." (Healthy City Project, 1992 p. 48)

From the results of the Health Profile it was found that families with children felt more exposed to traffic than other groups (Healthy City Project, 1994a). The Medical Office of Copenhagen was subsequently instructed to undertake a study on the risks to children from air pollution. This found

that the effects of traffic pollution on ill-health may contribute to about 5% of various respiratory diseases in children (Medical Office of Copenhagen, 1992).

The Health City Project then used the results from the Health Profile to highlight the public desire for action from the Council on traffic issues. Egsgaard felt that the project was able to provide a valuable perspective because health was not usually associated with transport planning.

"A lot of people urged us to do something about traffic because this is really a big issue... many people feel that there are a lot of decision makers in the field of traffic already so we were just an extra. So we were surrounded by decision makers who had many views on this aspects. But we started of course from a different angle which was the health angle."

(Interview with Jens Egsgaard, Healthy City Coordinator, July 1995)

Egsgaard believed that the Health Profile was also important in influencing the transport planners, not least because the politicians were influenced by it. This was despite the fact that the Profile was based on perceptions about quality of life and not ill-health as traditionally conceptualised by transport planning professionals as measurements of pollution and the counting of accidents.

"Of course we discussed the figures in the health profile. How should we interpret it? Because when we look at the illness side we know that it is very difficult to see how much illness traffic creates. Anyway, we felt that the signal was very very clear to the politicians, even those who say that this is not health in the sense of illness, it's health in the sense of quality of life as much. But the signal is very very clear." (Interview with Jens Egsgaard, July 1995)

Egsgaard thought that Eir, the Transport Planner, saw the results and the political reaction to them as providing a way of progressing transport planning policy.

"I think that the real breakthrough about this came through Bjarne Eir, who is responsible for the day to day service, ... I think he felt that it was a very useful way." (Interview with Jens Egsgaard, July 1995)

This was confirmed by Eir, who noted that in the Health Profile there were considerable concerns about the amount of traffic and a wish to reduce it. The concerns provided the material for political discussions about what actions might be taken. There were:

"lots of reactions from the population saying 'here there is too much car traffic in our streets or in our housing area', and they, of course, are arguing that it is insecure and unhealthy and they don't like to live with this. And these arguments go into the discussions in the political field." (Interview with Bjarne Eir, July 1995)

Public perceptions were also viewed as important in the work of the Environmental Health Officer, Raymond Skaarup. He noted that even though the air pollution from traffic is not that bad in Copenhagen relative to other European cities, people are concerned that the air is polluted.

"People feel that the air pollution is the main problem. Maybe it is also due to when you have been outside Copenhagen and you enter the city and you smell the air pollution and that tells everybody that there is something in the air." (Interview with Raymond Skaarup, Environmental Health Officer, July 1995)

Skaarup highlighted a problem for the municipal authority stemming from this, that some of the wealthier families, 'good taxpayers', had been moving out from the city on account of their

perceptions of air pollution. The response from elected members of the authority was to instruct the Environment Agency to develop information campaigns to inform people about the air quality. The central campaign message was that it is possible to live in Copenhagen and breath unpolluted air. Even so, the Environmental Health Officer thought that some people would still prefer to live outside the city where they feel the air is better.

"People really don't care about levels and limits. They care more about what they feel and realise." (Interview with Raymond Skaarup, Environmental Health Officer, July 1995)

The second initiative of the Health City Project involving transport was the development of a Healthy City Plan. All WHO Healthy City projects are required to develop a Healthy City Plan although how they undertake the preparation of the Plan is for them and their respective municipal authorities to decide. According to the WHO, in Copenhagen the process by which the Plan was prepared illustrates the Health for All principle of intersectoral collaboration (WHO, 1994). The Roads Department made a significant contribution to the Plan during its drafting between 1992 and 1993. Egsgaard noted that because of the political interest in traffic issues, proposals for traffic had to be included in the Plan.

"The traffic chapter was very very interesting because... we were overwhelmed by decision makers. The traffic story was, I think, when we look at it from a health perspective, this has been an ongoing debate in Copenhagen. This is a hot political issue. We could not foresee making a plan of the city where traffic was not a part." (Interview with Jens Egsgaard, July 1995)

The Healthy City Plan was published in January 1994. The traffic chapter, which was informed by the 1991 Health Profile, set out new transport policy objectives as part of the Roads

Department's contribution to the Plan. The general aims of the transport policy for the period 1994-1997 were to:

- increase perceived traffic safety;
- continue to reduce road accidents;
- reduce air pollution;
- increase attention to noise levels, particularly near residential dwellings (reduce noise levels and protect residential dwellings from noise increases).

Within these overall aims were specific targets to promote cycling by extending bicycle routes by 20 km in four years, improve public transport infrastructure, and undertake further traffic management to route motor traffic away from sensitive areas (Healthy City Project, 1994a).

Egsgaard thought that the Roads Department's contribution to the Plan was substantive. He suggested that this was because of the relatively good traffic situation in Copenhagen: the decline in motor traffic since the 1970s, and a significant reduction in traffic accidents over the same period. Reducing traffic accidents and ensuring the smooth flow of the traffic are often key objectives for road and traffic departments. The relatively good traffic situation in Copenhagen, Egsgaard thought, gave the Roads Department a certain degree of confidence that it could address issues beyond its traditional areas of concern and made them receptive to new ideas. The Health Profile provided the Roads Department with an opportunity for a new approach to help maintain the favourable balance between cycling, walking, public transport and car traffic.

"My feeling about the traffic sector generally is that they are quite receptive to new kinds of activities. And it comes from the general success in reducing accidents. Because although they might not have done a great deal it has had a fairly dramatic effect on the number of

accidents and this gives people some confidence.” (Interview with Jens Egsgaard, July 1995)

This view was confirmed by Bjarne Eir when he talked about transport’s impacts on health. Eir firstly noted the continued decline in accidents, as well as the often immediately evident environmental disbenefits such as air and noise pollution from motorised transport. Secondly, he raised the issues of quality of life and the health benefits of cycling as well as the accident risk.

“Well, the traditional way of thinking on health for a traffic planner or engineer is to mention accidents and things connected to that. And we have been working on that aspect steadily over the years and we have had a situation where the number of accidents has been in decline...Of course there is air pollution and noise and the health consequences of that. And recently people are beginning to be aware that bicycling, may be it has a higher accident rate, but on the other side is that people who bike normally also have a more healthy constitution, may even live longer and have a higher quality of life and so on.”
(Interview with Bjarne Eir, July 1995)

There are substantive proposals for the further development of cycling infrastructure in the Healthy City Plan. Support for cycling in the Plan is illustrated by the ease with which proposals to develop more facilities for cycling were accepted by both the politicians and city administrators even though there were cost implications arising from the proposals and no budget previously identified for the measures Eir proposed for cycling in the Plan. He noted that he had sent his proposals directly to the Healthy City Office without his Director having seen them first. He did not expect his own proposals to be incorporated into the Plan without his Director having the opportunity to check them first. Eir’s draft proposals were, however, written into the Plan.

"I write my part of it and send it directly to the working group. My boss didn't see it, he got a copy, my chief city engineer didn't see it before, he got a copy. Our Mayor also got a copy. But I wrote it, what I feel in my heart, this ought to be our policy. It was not opposed to the general plan but it went far further. So I was a little bit... I hadn't foreseen that it would go right through and in to paper unchanged. I think that that's all right. It has been approved by the politicians but if the administration had put it aside then nobody could have claimed [objected]. But there are people in the administration who think this is right and we have to work on this lines... It gives legitimacy for those people in the administration who are working along these lines. It is remarkable that I could say bicycle traffic should be promoted by the following initiatives: the next four years 12 kilometres of bicycle lanes; next four years 20 kilometres of bicycle routes and so on, exactly. And I have no economy (budget) for it, I have no approval from politicians or anything, just ... and now we have established 9 out of this 12 kilometres and we are working on the 20 kilometres and so on. So it has been very optimistic to see that." (Bjarne Eir, July 1995)

As a result of the collaborative work in developing traffic initiatives for the Healthy City Plan, in the summer of 1995 Egsgaard was working with Eir and the Roads Department to develop a public information programme about the health benefits of cycling. Such collaboration had not been undertaken previously.

"I think that the next issue they will take up is the exercise bit of the plans from traffic. We have just started a biking project on health. It gives the facts about cycling and health. We started on a small scale and we are trying to make it bigger." (Interview with Jens Egsgaard, July 1995)

6.6.3 The influence of the Public Health Insurance Act

The Public Health Insurance Act which came into force on January 1st 1994 stated that planning for health promotion is a mandatory responsibility of the counties and municipalities. This section explores what effect the interviewees thought that the Act had had by July 1995. The Healthy Cities National Coordinator, Kit Broholm, believed that the Act helped the municipalities to be more systematic in health promotion planning.

[The municipalities] *"think more systematically about how they could use health promotion as a tool instead of just curing. So we hope that this health planning, which is a law in Denmark... they have to do these things within four years."* (Interview with Kit Broholm, Healthy Cities Network Coordinator, July 1995)

The Healthy City Coordinator noted that the Act was promoted by those working in health promotion as a way to increase the influence of health in municipal authority work, and that the Minister of Health was 'favourable'. While not feeling able to identify any particular actions which persuaded the Minister, he thought that there was consistent pressure for the legislation from people working in health promotion to demonstrate a consensus. As noted above, this was framework legislation, in line with Danish governmental legislation since the 1970s. It did not stipulate how each municipal authority was to undertake the task.

"It was very important to point out that this was not Stalinist planning where the State should decide for you. They only put down a framework that you should do something."
(Interview with Jens Egsgaard, July 1995)

Kit Broholm, reflecting on a recent study tour of Scotland, thought that one of the significant differences between Denmark and the United Kingdom was that there was support from the Ministry of Health for health promotion in Denmark. This was because there was consensus as to

the problems needing to be addressed, such as inequity, but that this was not necessarily so in the United Kingdom.

"We have had very strong support from the Ministry of Health... of course we have inequity in Denmark, and in the Healthy Cities Network in Denmark we are trying to think 'how can we work with that?' because most of it is social stuff that we as health workers can't do anything about. It is not enough that we do what they do in England because that problem... our Ministry doesn't deny that the problem exists. They want us to do something about the problem." (Interview with Kit Broholm, July 1995)

6.6.4 Influences on transport and health collaboration

Previous sections have provided examples of how the Healthy City Project had been able to engage with the Roads Department, notably through the development of the Healthy City Plan. This section explores some of the factors that have positively influenced collaboration and also notes barriers to collaboration identified by the interviewees. Firstly, it addresses the issue of the organisational structure of municipal government in Copenhagen and whether it helped or hindered collaboration. Secondly, it examines the influence of the political culture on attempts at collaboration, and thirdly, the influence of professional cultural factors.

6.6.4.1 The influence of organisational structure

The presence of a Healthy City Project office and staff working to raise the profile of health within the organisational structure of the municipal government had resulted in some specific efforts to promote dialogue and intersectoral collaboration. This included the survey from which the Health Profile of the public's views and concerns about health was produced. The Healthy City Project Coordinator thought that, in some ways, intersectoral collaboration was aided by the organisational structure in Copenhagen. This was so to the extent that:

"if you look at Copenhagen from the structural side I would say that, in principle, it [intersectoral collaboration] should be easier. You have a unitary system involving the social services, the health care system, and schools and environmental services."

(Interview with Jens Egsgaard, Healthy City Coordinator, July 1995)

The Healthy City Plan noted that making intersectoral and inter-disciplinary collaboration work was mainly a question of the ability to communicate and to take part in dialogue (Health City Project, 1994a). Egsgaard's perspective was that for intersectoral collaboration to work a level of common agreement had to be identified. This differed depending on the departments and individuals he dealt with. Early experience from the project's work had been that the various departments were not proactive on health issues and needed to be guided closely as to what actions they might take. They tended to think of health as being the responsibility of the Health Services Department.

"If we were going to get anywhere I had to come up with specific proposals for each department as their contribution to health promotion. They just don't come up with it by themselves... Many departments in Copenhagen feel that the core of health promotion is here, it's in this office." (Interview with Jens Egsgaard, July 1995)

Specifically regarding intersectoral collaboration on transport and health, the experiences of the Transport Planner did not lead him to see the structures as particularly advantageous in terms of facilitating intersectoral collaboration as opposed to any other organisational structures he was aware of. Eir noted that

"we too are specialising on our specific subjects and we are making a culture in this part of the administration and I don't think that we could say honestly that we have a more holistic view than any other authority." (Interview with Bjarne Eir, Transport Planner, July 1995)

Certain professions, however, had some existing intersectoral experience on health issues, not least staff working in areas of medicine and health where research had been undertaken on aspects of transport's impact on health. For example, the Medical Office of Health had undertaken a study on child health and air pollution in the city (Medical Office of Health, 1992). Ann Rindel, the epidemiologist, who had worked on this project, thought that collaboration on transport issues was not that difficult because of the organisational structure.

"We are involved in traffic planning because we are part of the city authority... In Copenhagen the structure makes it slightly easier." (Interview with Ann Rindel, Medical Office of Health, July 1995)

6.6.4.2 The influence of political culture

It was noted by several interviewees that political rivalries could make intersectoral collaboration difficult. The Environmental Health Officer described how the political affiliation of the Mayor heading his department influenced the policy of the department. He recalled that there had been a number of Mayors of differing political persuasions in recent years so that the policy changed somewhat as a result. There had been a very left wing Mayor who wanted to take certain actions on pollution issues but the Lord Mayor blocked her attempts to do anything. In general, Raymond Skaarup felt that the politicians were too pro-car because of concerns not to undermine business through traffic restraint measures. This was despite the policy set by the politicians, over many years, to reduce motor traffic levels in Copenhagen. Skaarup noted that at one time:

"it was a Social Democratic Mayor and for a lot of years they were only pro-traffic. Pro-traffic because it was also seen as being pro-commercial. There are a lot of theories which say that if we regulate traffic we also spoil the commercial prosperity. But the Social Democratic party seems to change in that behaviour but still there is a lot of interest

pointing at the need to have traffic through Copenhagen, unlimited traffic.” (Interview with Raymond Skaarup, July 1995)

Skaarup noted that the party political Mayors responsible for each of the six departments had clear vertical but not horizontal lines of communication and command. This was both a hindrance and a help, according to Skaarup. The Mayor responsible for environmental policy had no powers to influence transport policy despite the fact that the major cause of air pollution in the city was motor vehicle emissions. This meant that the Environment Agency could only measure pollution levels from traffic but not take direct action. This led to a view that there was little the Environment Agency could do but to provide information, and also that it was the responsibility of the Roads Department to take action to reduce traffic generated air pollution.

“If you ask me what we do about it I can pretty freely say I don’t do anything about it, it’s not my responsibility. So on one hand it’s easy... We can make information campaigns to tell people how to avoid things or to behave in a special way to compensate for the missing power of regulating, and I like the information campaign principle a lot. So it’s not that clever or that practical for the development of sustainable planning or ... but on the other hand it can be convenient.” (Interview with Raymond Skaarup, July 1995)

Yet, to be effective beyond providing information about air quality, Skaarup saw the need for collaboration because of the large amount of road traffic generated air pollution. Proposals contained in a draft of a new transport and environment plan, being developed during 1995, provided a rare opportunity for collaboration with the Roads Department.

“The dialogue could be better but it could also be worse because now I think this traffic plan makes everybody think about what they want and it starts collaboration.” (Interview with Raymond Skaarup, July 1995)

Eir commented that the municipality of Copenhagen had a government structure which was very old and very stiff. There were institutional conflicts between the different parts, but he thought that these were typical of large organisations. Discussion with colleagues in other departments was not difficult but taking action jointly could be because of political rivalries.

"Normally we are speaking freely to each other and we can speak to each other but when it comes to acting and so on it sometimes becomes a little bit difficult because we have different Mayors and our Mayors have different political backgrounds. One department has a Conservative Mayor, another one has a left wing socialist and so on. So that can give problems in the municipality." (Interview with Bjarne Eir, July 1995)

This rivalry was also commented on by Egsgaard, and this, together with the size and consequent bureaucracy of the Council, gave him some cause to doubt how well-suited the organisational structure was in enabling intersectoral collaboration to happen. This was despite Copenhagen being a unitary government with little recourse to higher government in decision making.

"The system is also very competitive in Copenhagen. There is a competitive system between the Mayors. And also between the administrators... I would like to say that it should be easier for us [to collaborate intersectorally] but I am not that sure that it has been in actual fact. Size could be another factor because size tends to build up bureaucracy." (Interview with Jens Egsgaard, Healthy City Coordinator, July 1995)

The politicians' willingness to acknowledge public concerns' for health, as identified through the Health Profile, did mean, however, that the Roads Department could attempt to accommodate such concerns even though they were not quantified. This action could be attempted irrespective

of the degree of scientific uncertainty about the health impacts since it was viewed as a matter politicians could lead on. As Eir noted:

"I don't feel that the health arguments are standing very clearly as the first point... But under the surface there is a strong feeling. There is agreement in the political aspects on that, in that we don't like to have more car traffic in the city. Most of the politicians even want to reduce the number of cars. And that is from the feeling that it is unhealthy to have so many cars and so pollution and all the consequences that follow." (Interview with Bjarne Eir, Transport Planner, July 1995)

6.6.4.3 The influence of professional culture

There were also some influences on collaboration relating to differing professional cultures. In developing a new transport plan for the city, Eir had been trying to work intersectorally but had found that both environmental and public health staff focused largely on the quantifiable evidence relating to traffic and health. Eir thought that the difficulty with the quantitative approach was that it was limited by the number of aspects which could be quantified. He felt that the environmental and public health staff were rather too focused on wanting to quantify effects.

[They] "want to have numbers and proof that this and this will work in this and this way and will give that effect and so on. Both the environmental people and the health people have a tendency to state what we can quantify, air pollution, noise, accidents ... and the health side is very much more difficult to have the connection to traffic. They try to do that but I think it is the wrong way. It is very difficult to discuss these things." (Interview with Bjarne Eir, July 1995)

In contrast, Eir thought that having worked as a traffic planner for many years had enabled him to think more freely than those bound by single discipline approaches. Despite originally being

trained as a traffic engineer, Eir had taken a less positivistic stance in his work. He found the Health City Project approach, and particularly the evidence from the Health Profile, more engaging than simply relying on quantitative data.

Eir perceived transport and health issues in terms of the need for a balance between the quantitative and the qualitative. This, he thought, was to be achieved through the professional maturity of those involved and led by the politicians. This approach gave some weight to quality of life issues, taking account of how people felt, when decisions were being made.

"The traditional way of looking at that in my profession is of course facts, number of accidents and so on, and the other things that you are mentioning that's a political question. The politicians have to take care of that and then, if they say you do so, then we do it. Of course that is personal feelings and not sustained by facts. That is the traditional view. I have never been able to work that way and all my time I have been in opposition to that so I have not been a normal civil engineer... You have to listen to people. We need to balance this in some way. It is a question of maturity in the professions, in the people, in the politicians, all who are involved in this and all who should take a decision in the case."

(Interview with Bjarne Eir, July 1995)

The issue of health and illness and quantitative and qualitative data was raised by Egsgaard in a markedly similar way to that described by Eir. He, however, did not see this issue as a matter of conflict or difficulty in Copenhagen, noting that both the Chief Medical Officer and the Director of the National Institute for Clinical Epidemiology were supportive of the 'practical sides of health promotion'.

"It goes into the nerve of health promotion because it has two sides. One is illness again and this is the scientific business, one is quality of life which is more or less a political

business with the decision making. So I think that the strict medical guys would go to the medical side and say 'what is the effect of this'?... It has not created any conflicts between professionals." (Interview with Jens Egsgaard, July 1995)

A quantitative approach was taken by Rindel, the Epidemiologist, who thought that with professions largely using quantitative data it was important to discuss matters in this way.

"I think that it is difficult because we have to have proof, then we do something. I think that in a way they [the municipality] were interested in that sort of calculations... If you are working with people who are positivistic it is important to quantify." (Interview with Ann Rindel, Medical Office of Health, July 1995)

6.7 Drivers of transport planning policy

6.7.1 Environmental influences on transport planning policy

Previous sections have explored how the Health City Project sought to collaborate with the Roads Department and what types of influences affected such collaboration. In this section the driving forces behind transport planning policy in Copenhagen are discussed. Central to these is the goal of reducing motor traffic levels. This goal underlay the traffic plan aims set out in the Healthy City Plan of reductions in accidents and pollution, improvement in perceived safety, and increases in cycling and public transport use. This was set out in Copenhagen's 1991 Municipal Plan:

"Further urban development must be planned to encourage the use of public transport. The reduction of individual car traffic is a long term goal for environmental and economic reasons. Future housing and industrial development shall therefore be located primarily in areas with easy access to public transport." (City of Copenhagen, 1991 p. 17)

According to Eir, the foundations for Copenhagen's current transport policy of car traffic reduction, were less well planned than official documents acknowledge. Unlike many other European cities which built major roads and motorways into and around their centres, Copenhagen did not, although it did plan to do so in the 1960s. The Ministry of Environment and Energy simply notes that plans to build 'access limited highways' in the city were abandoned in the mid 1970s (Ministry of Environment and Energy, 1995), while Copenhagen's City Engineer claimed that a single section of major highway was built in the early 1970s but no further major roads were constructed because 'it looked ugly' in the city's environment (Rørbech, 1990). Other reports describe the cancellation of transport infrastructure projects in terms of economic stagnation during the early to mid 1970s (TEST, 1989; Jensen and Jørgensen, 2000).

Eir provided his personal interpretation of why major road construction did not take place in Copenhagen. This related to Danish politics during the 1960s and 1970s. At this time one third of all Danes lived in the Greater Copenhagen region and this was increasing year on year. Populations projections were that more than half the population would live in this region by the late 1970s if the trend continued. The region was governed by Social Democrats while the country in general was politically controlled by Conservatives. The Conservatives feared that the rise in the population living in the Greater Copenhagen region would give the regional Social Democratic government considerable influence over national policies. Eir asserts that the Conservatives deliberately starved the region of virtually all funds for infrastructure development, especially on traffic. The outcome was that the population growth halted, and economic development was suppressed. If, however, the funds had been available the municipal and regional governments would have built major roads in Copenhagen, as was the case in many western European cities during this period. Eir stated that:

"less than one per cent of the State's investment in traffic infrastructure was placed in this region and so in the municipality of Copenhagen... In the Copenhagen regions there were

no investments and the Copenhagen region had to pay 7 billion kroner per year to the rest of Denmark. So we had at least 20 years of suppressed economic situation in the region. The population increase stopped and we have nearly a stable population during this 20-25 years. So it gives a little bit of an overall background for the situation which means that we have had very little renewal in the traffic infrastructure in the Copenhagen region. And you could say that that has been good luck because if we had had the money we would have used it in a stupid way of course! It is a little bit of a poor background, you could say. So our situation, which is lucky in some ways, because we don't have so much car traffic in this town. We have a lot of bicycles, a very nice modal split between between the modes."

(Interview with Bjarne Eir, July 1995)

By the early 1990s the lack of major road construction in Copenhagen and the viability of alternatives to the car meant that the city was in a strong position in terms of government objectives to control motor traffic growth and vehicle emissions, as set out in the 1990 Traffic Action Plan and the 1993 White Paper Traffic 2005. Eir considered that the relatively high levels of cycling and public transport use gave:

"a good contribution to the goals set up in these papers. It is a result of what we are doing from day to day and the general situation." (Interview with Bjarne Eir, July 1995)

To achieve the goal of car traffic reduction, the Roads Department, at both the officer and political level, was willing to engage with other departments of the City Council which were seen to offer assistance in meeting this goal. Egsgaard, for example, noted that it was Eir who wanted to develop the health arguments. Eir saw that he had political support for this, and found that the approach stimulated significant interest when he presented a paper about the development of a healthy traffic plan to an international conference in September 1993.

"We didn't know how the traffic sector would react to this, but I think he [Eir] found it very interesting and he, while we were actually working on the plan and trying to finish it, he presented this in Nottingham, which created a lot of interest. This only furthered his interest. He felt even more the way I felt about it. He felt even more confident about this approach because this created a good discussion." (Interview with Jens Egsgaard, July 1995)

The fieldwork findings suggest that the Roads Department had been focused, over a number of years, on implementing policies to reduce car traffic in Copenhagen. The Health City Project's work, including the information from the Health Profile was viewed by Eir as providing further assistance in this task. In contrast, despite concerns about traffic generated pollution, as identified in the Health Profile, there was little evidence of collaboration involving the Environment Department prior to 1995. Although Eir noted that he had some contact with the Environmental Health Department because of air pollution issues, Skaarup claimed that until 1995 there had been virtually no collaboration between his department and the Roads Department. He saw the reason for this being that the traffic planners perceived air pollution to be low in Copenhagen and so thought that air quality was not a problem. According to Skaarup:

"we have not done that much work with the traffic department... But that department (traffic) has not been focused much on environmental matters or consequences of the traffic. It seems that they have a view that it is not a problem. Air pollution is low and due to that we don't have to worry about it. This seems to have been their attitude. Due to that I have never actually been meeting these people but there is the start of some work now."

(Interview with Raymond Skaarup, July 1995)

According to Eir, the quantitative approach employed by the Environmental Health officials, did not address public perceptions. Public perceptions of air quality, as identified in the Health

Profile, were used by Eir to help progress policies which gave greater priority to alternatives to the car.

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Chapter 7

The English case study

7. Introduction

Rationale

During the period of study, 1986 to 1996, English transport policy was not noted for its environmental content. The city of Sheffield, where fieldwork for this chapter was undertaken, did, however, have the legacy of a cheap fares policy between the mid 1970s and mid 1980s which had led to a lower level of car ownership than in cities of comparable size and population. Sheffield was also one of the first English cities to develop a Health for All project, in 1987. This chapter explores how far concerns for health have had an influence on road transport policies in Sheffield.

Sources

One main source of data for this chapter is the collection of published documents from the Department of the Environment, Department of Transport, and Sheffield City Council. The other main source is interviews held with four key actors/informants. Three of these were located within departments of Sheffield City Council. Nick Silvani and Cate Jockel worked as transportation planners in the Transportation Planning Unit which was located within the Planning and Economic Development Department of the City Council. Valerie Cotter was based in the Health Policy Unit within the Environmental Health Department of the City Council. For half of her time she was employed by Sheffield City Council as Health Policy Coordinator, and for the other half by the local health authority as Assistant Healthy Sheffield Coordinator. Her position, working within the Environment Health Department gave her insight into the views of that department and its particular perspective on health and transport. A fourth interviewee was Dr Jeremy Wight, a Senior Registrar in Public Health, working for Sheffield Health, the local health authority, who was responsible for transport issues.

Focus

The chapter sets out the findings from primary data and fieldwork. It is divided into two main parts. Drawing on primary data, it first addresses the policy context at the national level, beginning with a review of the main influences that have steered the direction of English disease prevention and health promotion work. As in the Netherlands and Denmark, the development of Health for All policy and targets by the World Health Organisation has been important. How these have been incorporated into health promotion and prevention policy both at the national and the local level is explored.

Secondly, the development of transport policy is reviewed, again drawing on primary data. Policy has been differently oriented to that in either the Netherlands or Denmark. From 1989 the stated main objective for the Department of Transport was implementation of an expanded roads programme, the extension of a transport policy which began to dominate the policy area from the 1950s. By 1996, however, policy was in a period of change. There was some signs of collaboration between the transport and health sectors to promote alternatives to private motorised travel.

The second half of the chapter sets out the findings from a study of the city of Sheffield. It begins with information concerning the city's recent history, and the City Councils' structure and organisation. A significant reorganisation of local government in South Yorkshire occurred in 1986 with the abolition of the metropolitan authority. In addition, the role of the health authority as the local health service provider is explained. As noted in Chapter 3, unlike in the Netherlands and Denmark, English health services reside outside the local government structure.

The case study explores Health for All work in Sheffield and its influence on transport planning. This is seen to be focused particularly on air pollution issues, commencing in 1995, eight years

after the establishment of Healthy Sheffield. Some barriers to the development of work on transport and health are identified, with a significant barrier, as perceived by the Transportation Planners, being the lack of effective intra-sectoral collaboration. The chapter concludes with a discussion about the main drivers of transport policy in Sheffield.

7.1 The national framework for health and transport work: an overview

7.1.1 Government structure and organisation

There are two tiers of government in England: national and local. Parliament has existed as a representative body since the 13th century. Located in London, there are two chambers of Parliament, an elected lower house, the House of Commons, and an unelected upper house, the House of Lords. There are some 650 elected Members of Parliament, each being voted to serve a geographical constituency in either England, Wales, Scotland or Northern Ireland. Elections are held every five years. There are approximately 410 English district councils, with powers to control land use planning, and an additional 120 highway authorities consisting of County Councils and Metropolitan Councils. Local government politicians are elected for a period of three years with elections being held most years to elect a proportion of local politicians. There are approximately 36 million people eligible to vote in England.

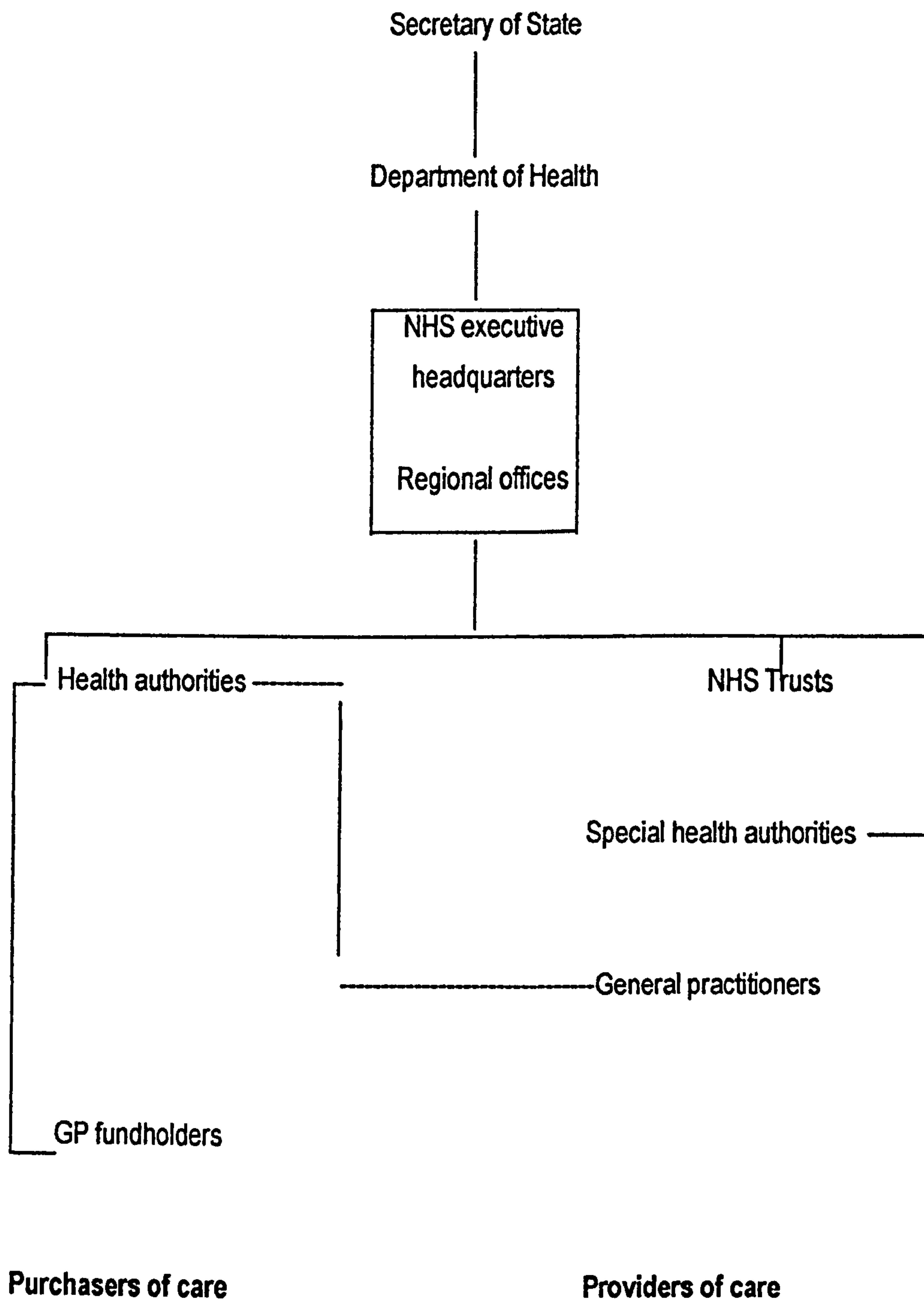
National government is responsible for producing transport and related planning policy. White Papers on transport policy set the policy steer and each spring highway authorities are provided with guidance from which they develop and submit their transport policies and plans for the following year (called Local Transport Plans since 1999-2000). Likewise, planning policy is set out in White Papers and detailed guidance is provided through occasional Planning Policy Guidance Notes.

Funding for local government services comes from a mix of rates payments collected from the local residents and businesses, as well as through funds from central government. In England,

central government controls around 80 per cent of local government funding by means of an annual financial settlement allocated through the Department of the Environment (the Department of the Environment, Transport and the Regions from 1997). Central government can, and sometimes does, set a 'cap' on the amount a local authority is legally allowed to spend on local services.

Health care services and health promotion reside within the National Health Service (NHS) which was established by the 1946 NHS Act. The NHS is publicly accountable to, and through, the Secretary of State for Health. Health authorities and trusts also appoint their own Boards to oversee management which on a day to day basis is the responsibility of the Chief Executive. Between the 1970s and early 1990s there were a number of reorganisations within the NHS. In 1995 many of the functions of the Regional Health Authorities were transferred to individual health authorities and trusts, with the commissioning of health services becoming separated from the provision of those services. The new structure is set out in Figure 7.1.

Figure 7.1 The structure of the National Health Service (as of 1995)



Source: Ham 1997

General Practitioners play a central role in primary health care, but dentists, health visitors and practice nurses, among others, are also important. Such health workers are either employed directly by the state, as are health visitors, or contracted to work for the NHS, as in the case of General Practitioners.

7.2 Policies for disease prevention and health promotion

7.2.1 International health policy influences

As with the Netherlands and Denmark, England has been influenced by the development of the Health for All by the year 2000 strategy and targets. Health for All was endorsed by the Government in 1985. Health for All projects were established across the UK from the latter half of the 1980s (as was the case in the Netherlands and Denmark).

As noted in the previous chapters, the Health for All targets were revised in 1991, two of which specifically refer to transport. Target 11 makes reference to road traffic accidents, and target 19 addresses the impact on environment and health of policies and strategies in sectors such as urban planning, energy, industrial development and transport. In addition, target 1 is concerned with equity and health, target 2 is focused on health and quality of life, target 18 addresses the need for multi-sectoral policies, and target 24 addresses human ecology and settlements (WHO, 1991), areas with direct links to transport because of the impact of motor traffic on the natural and built environment. Health for All has been reflected in Department of Health policies, the most significant of which during the early 1990s was the White Paper, The Health of the Nation (Department of Health, 1992a).

7.2.2 National and local health policy responses

Health policy is updated every few years by government. In 1992 the Government set out its health strategy in the White Paper, The Health of the Nation. This set five 'Key Areas' for action: coronary heart disease and stroke; cancers; mental illness; HIV/AIDS and sexual health;

accidents. As noted in Chapter 3, all of these key areas relate directly to Health for All: coronary heart disease corresponds to Target 9 on reducing cardiovascular disease; cancers with Target 10 on controlling cancer; mental illness with Target 12 on reducing mental disorders and suicides; HIV/AIDS and sexual health with Target 5 on reducing communicable disease; and accidents with Target 11 on reducing accidents.

Within the White Paper it was stated that the continuing success of the NHS was to be achieved through improving quality of care, reducing waiting times, and increasing efficiency and value for money. The WHO Healthy Cities project (see Chapter 3) was acknowledged and the White Paper stated that the government was keen to ensure that the Health for All Network continued to provide a support service to towns and cities engaged in the development of Health for All.

“The Government is anxious that the Network continues to provide a means of exchanging information amongst participating towns and cities in England and, through WHO, into the wider European network.” (Department of Health, 1992a p. 26)

The Health of the Nation also emphasised the need for health services to collaborate with other agencies. In England, intersectoral collaboration has been emphasised within the health sector as a key element in the reorientation of health policy towards prevention and health promotion. As discussed in Chapter 3, this has been characterised as ‘healthy alliances’ in the Health of the Nation Strategy with local government being identified as a key partner in collaboration. Both within The Health of the Nation, and in a covering letter from the Secretary of State for Health sent to local authorities at the time of the launch of the White Paper, the importance of the role of local government in healthy alliances was stressed.

“Local Authorities are responsible for a wide range of public services, many of which impinge on health and are linked with the strategy set out in the White Paper; these

include education, transport, social services, environmental health and food safety. Their contribution is vital to the achievement of the strategy.” (Department of Health, 1992b)

During 1987-88, two English local authorities became official WHO Healthy Cities: the London Borough of Camden, and the City of Liverpool. By 1992 approximately 75 other towns and cities were involved in a national Health for All Network. This included Sheffield, which was one of the first English cities to become involved in Health for All, in 1987.

7.3 Transport policy developments

7.3.1 Policy drivers at the end of the 1980s

As was noted in Chapter 2, much of the focus of English post World War II transport policy was on building enough road network capacity to meet demand for private motorised travel. Termed ‘predict and provide’, this approach was manifested in the 1989 Transport White Paper, *Roads for Prosperity*, which announced a £12 billion roads programme for the coming decade (Department of Transport, 1989). As the title suggests, the White Paper was predicated on the view that road building was necessary in order to support the economy. Launched at the same time as the White Paper was the latest forecast for road traffic growth, of between 83 and 142% between 1988 and 2025.

The White Paper and the traffic growth forecasts were, however, to lead to increasing opposition from a broad constituency of local authorities, among others, which transcended political allegiance. The Association for County Councils, for example, controlled by Conservative local authorities, was one of the first local government representative bodies to set out a coherent policy which argued that the objectives of the White Paper were environmentally unsustainable.

“There is no possibility of increasing road supply to a level which would match the growth in demand. Such an increase, even at the lower end of the scale, represents an order of

growth for which in many specific places, and in total, it is unacceptable environmentally to provide." (Association of County Councils, 1991, p. 8)

7.3.2 Environment as a policy driver

By the end of the 1980s and early 1990s the environment as an issue of public concern was high, as indicated through public opinion polls, membership of environmental pressure groups, and the amount of space allocated to environmental issues in the national press. Opinion polls suggested that concern for the environment had never been higher. An NOP poll for the Department of the Environment carried out in 1992, for example, found that 86% of people surveyed were either concerned or very concerned about the environment - higher than previously recorded (Department of the Environment, 1994).

During the late 1980s, the Department of the Environment was under pressure to take action to protect the environment from a range of threats which were increasingly being publicised through the national press. In response, in 1990 the Government published a White Paper on the environment, *This Common Inheritance* (Department of the Environment, 1990) (see Table 7.1). It was the first official response to the idea of sustainable development, as raised by the Brundtland Report in 1987 (see Chapter 2). *This Common Inheritance* included a range of environmental targets, some of which were transport-related. It committed the government to research ways in which the road transport sector could reduce its contribution to carbon dioxide emissions.

By 1994 there was evidence to suggest that transport policy had begun to change away from predict and provide. In March the Departments of Transport and Environment jointly produced *Planning Policy Guidance on Transport* (PPG Note 13) (Department of the Environment, Department of Transport, 1994). In this guidance, planning policy was to be used to steer new developments towards existing settlements in order to reduce the need to travel, and in particular

the need for motorised travel. The interrelationship between landuse planning and transport was substantially strengthened through this document and was based on the need to reduce the national contribution to carbon dioxide emissions, as identified in This Common Inheritance. Research which underpinned the development of the Guidance had calculated that emissions could be reduced by up to 15% over a 25 year period compared with existing projections. At the local level such policy changes encouraged greater integration between landuse and transport planning. Highway authorities can also be planning authorities, and since 1986 Sheffield City Council has been both.

In terms of local transport planning, each highway authority is obliged to submit a bid for funds to the Department of Transport by the end of each July. In this bid, the Transport Policies and Programmes document, the authorities set out their policies and plans for the next financial year and apply for funds, such as for new road schemes, traffic management, road safety schemes and roads and structural maintenance programmes. Prior to 1994 there was no requirement by the Department of Transport for highway authorities to demonstrate that they had an integrated programme which sought to meet the needs of all types of road users. In 1994 this changed with the introduction of 'Package funding', which was a response to criticisms that local authorities sometimes had narrow policy objectives, particularly oriented to road building. In December 1992, the Secretary of State for Transport, announced that there would be a new strategy for funding transport expenditure in urban areas.

"I have concluded that a package approach is desirable for planning local authority transport expenditure in urban areas: and there should be greater flexibility, within the constraints of existing legislation to switch resources between different forms of transport."
(Department of Transport, 1992)

In April 1993, the annual Transport Policies and Programmes Submission Circular was published by the Department of Transport, in which local authorities were formally invited to submit package approach bids. For 1994-95 this was not mandatory although local authorities were:

“encouraged to consider whether a package-style bid might be beneficial, especially for the larger urban area within their boundaries...[and] the package approach is expected to be the norm for urban areas from 1995-96.” (Department of Transport, 1993)

From 1994 the guidance became increasingly focused on schemes to promote alternative forms of transport to the car. Measures to promote walking and cycling were favoured by the Department of Transport and in a reversal of the situation prior to 1994, road schemes became the exceptions rather than the norm. By this time, the Department of Transport's stance was that road building in urban areas was generally undesirable given that building extra road space would be unlikely to reduce overall traffic congestion. This view was confirmed by the findings of a report from an advisory committee to the Department of Transport in 1994. The Standing Advisory Committee on Trunk Road Assessment (SACTRA) concluded that new roads ‘induced’ extra traffic of an order of between 20-30% over and above the predicted growth in traffic normally calculated for in the planning of the road (SACTRA, 1994). This policy change away from road building was supported by the publication, in September 1994, of the UK Strategy for Sustainable Development (UK Government, 1994). In this, greater attention was given than in previous policy documents to the need to strike a balance between economic development and environmental protection. In a climate of public opinion concerned about environmental degradation, issues of sustainable development were increasingly acceptable in policy development, enabling the Sustainable Development Strategy to state that:

“the main goal for sustainable development in the transport sector must be to meet the economic and social needs for access to facilities with less need for travel and in ways

which do not place unacceptable burdens on the environment.” (UK Government, 1994 p. 16)

This led the then Secretary of State for Transport to launch a debate about transport. It was carried forwards by his successor so that in publicising the April 1996 Green Paper on Transport, Sir George Young, was able to state that reducing the environmental impact of transport was a key concern.

“We all need to work together to ensure that viable alternatives are there, the measures to discourage unnecessary car use are in place, and that the environmental impacts of our travel behaviour are minimised.” (Department of Transport, 1996)

Table 7.1 Key government reports relating to English Transport and Environment Policy

1990 This Common Inheritance

was the first substantive policy statement by the British Government on the state of the environment and comprehensive national environmental strategy.

1994 Planning Policy Guidance Note 13: Transport

was focused on reducing the need to travel, and on the interrelationship between transport and land use.

1994 Royal Commission on Environmental Pollution 18th Report

on transport and the environment was strongly critical of transport policy and made over 100 recommendations for change.

1994 Standing Advisory Committee on Trunk Road Assessment Report on traffic generation

calculated that new roads 'induced' extra traffic over and above that normally predicted for in the planning of new roads.

1994 Sustainable Development Strategy

set out a strategy to reconcile economic development considerations with those of the environment. One section was devoted to transport.

1995 Transport: the way ahead (discussion paper)

a series of speeches made by the then Secretary of State posing questions about the balance to be struck between economic and environmental considerations.

1996 Transport: the way forward

a Green Paper on transport which sought to give greater consideration to environmental issues than previous government transport policy documents.

7.4 Integration between transport and health policy

From the advent of the first road traffic casualties at the end of the nineteenth century and during more recent decades, road accidents as a policy concern have provided the main reason for contact between the Departments of Transport and Health. Since the 1980s the two Departments have linked targets for reductions in road traffic accidents. For example, the Department of Transport established a one-third accident casualty reduction strategy in 1987 to be achieved by the year 2000. The target was incorporated into the Department of Health's own accident reduction targets. In the 1992 White Paper, *The Health of the Nation*, the roles of government departments were set out with regards to accident prevention and a national taskforce established with a representative allocated from the Department of Transport.

Such collaboration was less evident with regards to air pollution. For many years the Ministry of Transport's official position was that there were no harmful effects from vehicle emissions. For example, in 1967 the Ministry of Transport stated that 'no identifiable hazards to health exists' from air pollution by motor vehicles (Ministry of Transport, 1967). In 1979, one of the first acts of the newly elected Conservative Government was to abolish the Clean Air Council.

Concerns about air pollution grew during the 1980s and new evidence suggesting harm to health led the Department of Health to establish a number of committees during the early 1990s. These were charged with addressing specific aspects of air pollution. Liaison with other departments was mostly with the Department of the Environment (Department of Health, 1997). This was particularly so where public health officials in the NHS have been required to work with environmental health officers in local government since they are responsible for monitoring air pollution.

As discussed in Chapter 2, the launch of the National Cycling Strategy by the Department of Transport, and the issuing of a Strategy Statement on Physical Activity by the Department of

Health, both in 1996, did lead to some collaboration between officials from the two departments. Informal collaboration between the Department of Health's Health Promotion Division was established with Department of Transport officials dealing with the National Cycling Strategy largely because of the Department of Health's concerns with coronary heart disease and other illnesses relating to physical inactivity.

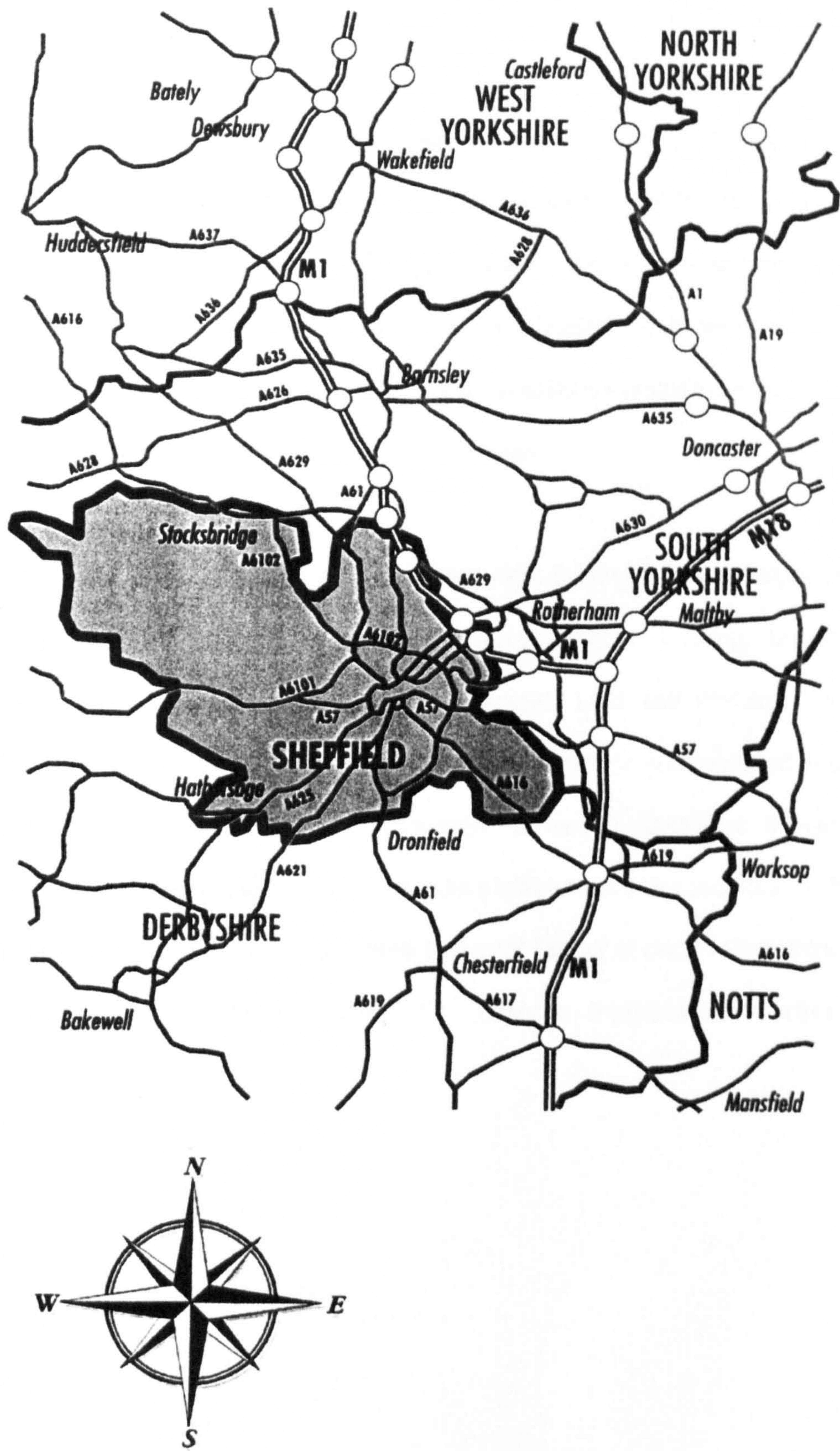
7.5 Sheffield

7.5.1 The city

Sheffield is the fourth largest city in England with a population of around 500,000, located in the south of Yorkshire (Figure 7.2). For more than a century it was dependent on steel and heavy engineering for much of its employment. During the 1970s and 1980s, however, Sheffield experienced massive economic decline, losing a total of 60,000 jobs between 1978 and 1988. Almost 29,000 local jobs were lost in manufacturing in the three years 1981-1984 (Sheffield City Council, 1984). By 1995, 27,718 Sheffield residents were unemployed, an unemployment rate of 13 per cent (in seven wards it exceeded 20%) (Sheffield City Council, 1994). In some city wards unemployment rates tripled between the late 1970s and mid 1990s. For such reasons, from the late 1980s, much emphasis was placed by Sheffield City Council, business interest groups, and the city's two universities, on the regeneration of the local economy. Partnerships between these and other agencies were developed to encourage enterprise, especially in the city centre, and around the Don Valley, the location of the old steel manufacturing industries.

During the 1980s Sheffield Development Corporation was established and it become responsible for land areas including the Don Valley. Development Corporations were introduced by the Conservative

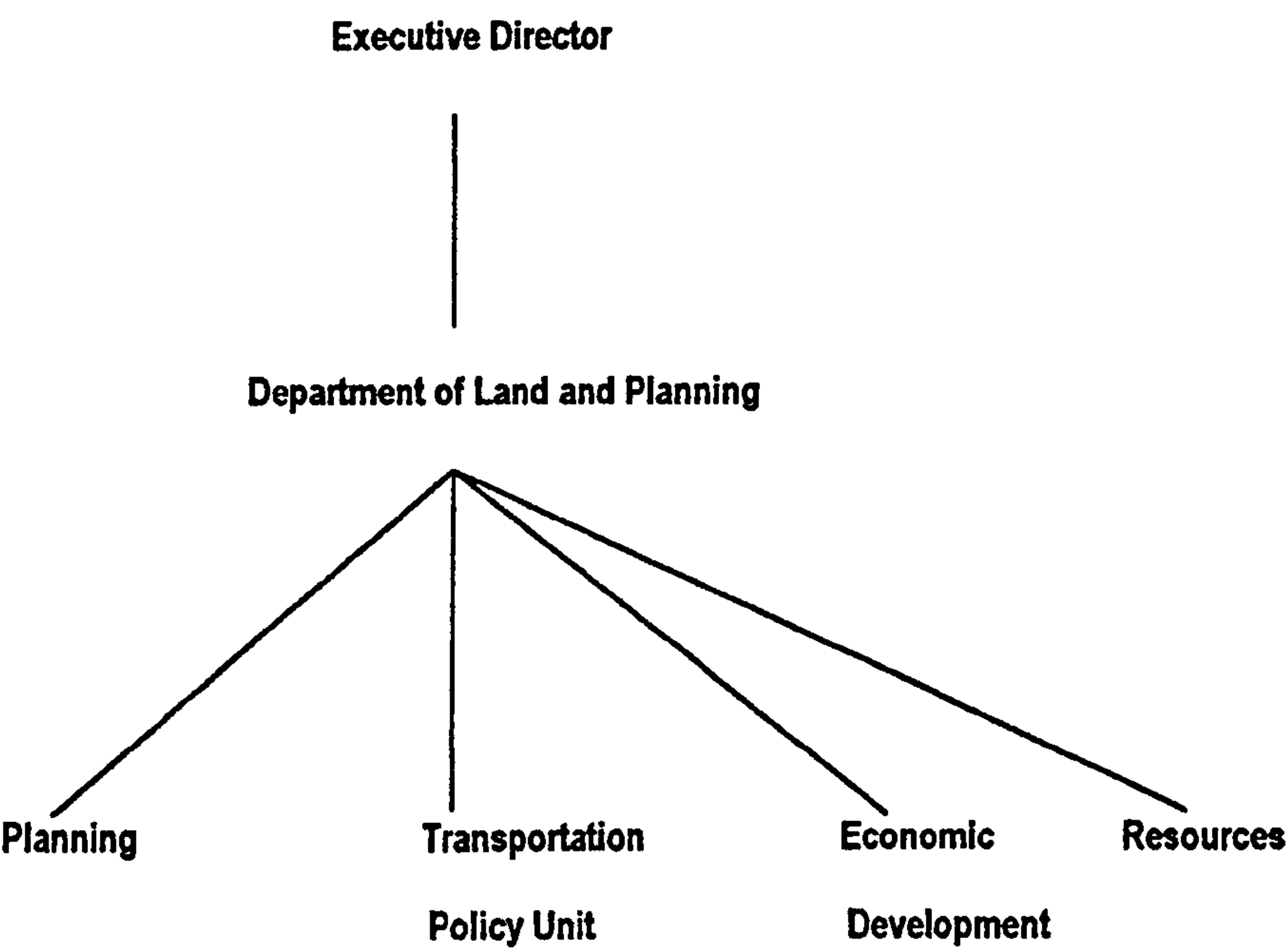
Figure 7.2 The location of the city of Sheffield



government at this time as a means by which regeneration programmes could be developed. They were given powers by government to help speed up regeneration projects. This included the Development Corporations' exemption from land use planning regulations. The Meadowhall site, located within the Sheffield Development Corporation area, was identified by developers in discussions with the Development Corporation. The site was accepted by Sheffield City Council on the basis that a shopping complex would be built somewhere locally, have an impact on Sheffield city centre, and that it was better for it to be located in Sheffield. A shopping complex located at Meadowhall meant that the Council would have some ability to manage travel demand, and benefit from the business rate which is paid to local authorities.

In 1996, Sheffield City Council had 12 departments. These were: Building Services; Corporate Services; Economic Development; Education; Environmental Services; Housing; Leisure Services; Library Services; Property Services; Social Services; Land and Planning; and Highways. These departments were overseen by an Executive Director who was supported by a small research unit. Each department was accountable to elected Councillors through committees which were responsible for initial decision making before major policy decisions, such as those with revenue implications, were considered by the full Council of elected Councillors. Figure 7.3 provides an overview of Sheffield City Council's organisational structure.

Figure 7.3 Overview of the organisational structure of Sheffield City Council
and the Department of Land and Planning



Plus Departments of:

- Building Services;
- Corporate Services;
- Economic Development;
- Education;
- Environmental Services:
- Highways.
- Housing;
- Leisure Services;
- Library Services;
- Property Services;
- Social Services.

Source: Sheffield City Council, 1996

The Labour Council in Sheffield retained a strong commitment to direct service provision during the late 1970s and early to mid 1980s. Total Council expenditure rose, partly reflecting an increase in the number of full time Council employees of 1,201 (6%). The required revenue was raised through the local rates. Sheffield City Council's budget was rate-capped in 1985 and 1987. The threat of further capping led to cuts in jobs and services in the late 1980s (Seyd, 1990) and during the 1990s.

In 1986 the Conservative government abolished the metropolitan authorities as well as the Greater London Council. The metropolitan authorities had been established in 1972 as part of a previous local government re-organisation programme. These metropolitan areas had all come to be politically controlled by the Labour Party, often with large elected majorities. Sheffield has been under Labour control since 1926 except for a brief period during 1968-1969. The demise of South Yorkshire Council did not affect the political control of Sheffield but it did end the ability that such bodies had to coordinate decision making in local government over a wide geographical area and population base. This ability to coordinate was particularly effective because the Labour Party also had political control of all the other former districts of South Yorkshire. This meant, for example, that a cheap fares policy for public transport had been implemented across all the four local authority districts of South Yorkshire. After the abolition of South Yorkshire Council, Sheffield, Rotherham, Doncaster, and Barnsley became separate unitary authorities, each responsible, for example, for highways construction and management. New structures and voluntary agreements needed to be developed where there was a consensus among the authorities as to the need for policy coordination.

As elsewhere in England, in Sheffield the Health Authority, Sheffield Health, provides local health care services and public health and health promotion functions. The latter form part of the Public Health Department. There are a number of 'outreach' offices located in districts where some health promotion officers work for part of their time. Sheffield Health is a member of the multi-

agency Health for All partnership, Healthy Sheffield, together with local businesses, the two Universities, voluntary sector organisations, and Sheffield City Council.

7.5.2 National influences on local policy

At the local level, conflict between the Departments of Transport and Environment in Whitehall were specifically identified by interviewees as having made transport policy implementation problematic. It was noted that John Gummer, as Environment Secretary of State, had implemented some important planning policy guidance to promote sustainable transport. This was seen to complement the perspective of the Transportation Planners who were trying to address inequities exacerbated since the deregulation of the bus services in 1986. They were trying to implement the planning policy guidance on reducing the need to travel. In contrast, the Department of Transport was still intent on increasing road network capacity as part of its roads programme. Transport policy was consequently being pulled in two directions.

"There is a straight contradiction between reducing the need to travel and not to cater for traffic growth, while the Department of Transport is widening motorways and still catering for traffic growth. That is the really big issue. Regional offices are a good idea. It would just be nice if the Departments of Transport and Environment talked to each other." (Interview with Nick Silvani, February 1996)

There were also tensions with national health policy at the local level. According to Valerie Cotter, Healthy Sheffield considered national health policy to be weak, focused on curing the sick to the exclusion of helping people to maintain their health. According to her, both The Health of the Nation document and national environmental health policies were limited in scope, and medically orientated in terms of health. They failed to address broad environmental issues including those which related to inequality and poverty. They could not, she thought, provide a framework for the more holistic approach towards health being taken forward in Sheffield.

"There are a whole range of things which we would consider as legitimate in our work in Sheffield which just aren't mandated within that document [Health of the Nation]. On the national environmental side the model of health which is often being applied is rather limited and very medically orientated. It is not about prevention it is about cure and regulation... we in Healthy Sheffield found it rather disappointing." (Interview with Valerie Cotter, February 1996)

Jeremy Wight, the Public Health Senior Registrar, thought that the effect of government policies, especially over the preceding 17 years, had been to erode a sense of welfare and so the acceptability of collective actions including health promotion. This, he believed, would have implications for approaches to policy even in Sheffield which he noted had a very strong paternalistic ethos through the Labour Council.

"I think that probably one of the longest lasting effects of those 17 years of Conservative Government will be the erosion of the sense of welfare. I fear that it will outlast a lot of the other things that the Conservatives have done. Even in a city like Sheffield which has got a very strong paternalistic Labour Council set up. The sense of community cohesion and community wellbeing is pretty thin. I sense that there is not that sense of welfare. That has consequences in the way one has to approach things because I think you have to put the selfish angle over. You have to point out to individuals the benefits that they as individuals would get if they take up cycling or use their cars less because, unfortunately, to argue from an altruistic sense of community wellbeing is not something which you can do... and so health promotion has suffered. The idea that health promotion is for the common good is just not there." (Interview with Jeremy Wight, February 1996)

7.5.3 Transport policy initiatives

Sheffield is probably most noted in European transport planning because of South Yorkshire Council's cheap fares policy, initiated in 1975, when fares were frozen until April 1986. By the end of this period typical fares were between 5p and 15p for a journey while similar journeys in other areas would have cost around 30p or 40p. Prior to bus de-regulation in April 1986, South Yorkshire had one of the most comprehensive and cheap public transport systems in the UK. The fares policy slowed traffic growth in the city and contained pollution levels more effectively than in other UK cities of comparable size and population. Although it was primarily driven by social policy concerns, to promote equity in access, other benefits were noted to be important. There was a large decrease in fare prices in real terms over a ten year period, and increases in bus patronage relative to other metropolitan counties during the early 1980s, resulting in an actual increase in distance travelled by bus (Goodwin, 1983). There was a small decline in car use over this period. The public transport subsidy benefited the health of the local population by providing the social amenity of additional travel at the least additional health cost (Nicholl, Freeman, Williams, 1987). This policy ended with bus de-regulation, stemming from the Conservative government's 1985 Transport Act.

As noted in Chapter 2, after bus deregulation, when bus fares rose by 250% in South Yorkshire, the unemployed and the retired reduced their bus journeys by over 62% and 60% respectively compared with a 37% reduction for those in work and a 48% reduction for school children. Free travel for pensioners and people with disabilities was ended. Additionally, social support networks suffered as travel to undertake informal caring roles were more difficult to make. This resulted in an increase in requests for statutory support services including home helps (Sheffield City Council, 1987). The change in public transport patronage before and after bus de-regulation is illustrated below in Table 7.2 and shows a continuing decline in public transport use (in line with a decline nationally).

Table 7.2 Changes in bus patronage in South Yorkshire

	Trip rate per person per day	Implied annual trips county residents (at 300 'weekdays' per year)	% change per year since last survey
1981	0.662	258m	-
1984	0.692	267m	+1%
1986	0.637	244m	-4%
1988	0.565	215m	-6%
1991	0.432	163m	-9%

Source: South Yorkshire Household Travel Surveys

In contrast, there were considerable increases in car use in South Yorkshire after bus de-regulation. Table 7.3 suggests a forty-two per cent increase in car travel in the South Yorkshire area, much greater than for Great Britain as a whole over the corresponding period.

The figures are indicative of the fact that the percentage share of people crossing Sheffield's Central Area Cordon by public transport and by private motor vehicles changed considerably after the ending of the cheap fares policy and bus de-regulation in 1986. In 1980 55.6% of people came into the central area of Sheffield by private motor vehicle. This percentage remained largely stable until bus de-regulation when there was a notable increase. Since then there has been a year on year increase in travel to the city centre by private motor vehicles so that by 1996 68.8% of all people travelled by this means, an increase of 20% since 1985. In contrast, bus and coach passenger percentage share, having been stable until bus de-regulation, fell from 44.4% in 1980 to 28.3% in 1996, a fall of 36% (Sheffield City Council, 1997).

Table 7.3 Changes in local car travel in South Yorkshire

	Local car driver trips/ person	Average distance (kms) of local car driver trips	Average kms per person per day	Average local kms per person per year
1981	.77	4.93	3.79	1383
1984	.73	5.03	3.67	1340
1986	.82	5.06	4.15	1514
1988	.90	5.30	4.77	1741
1991	.93	5.78	5.37	1960

Source: South Yorkshire Household Travel Surveys

In 1995, the introduction of the Supertram revitalised interest in public transport within the city despite patronage levels falling short of predicted levels (Local Transport Today, 1995). The Transportation Planners felt that there was a strong residual feeling of appreciation among the public for the cheap fares policy in Sheffield. Nick Silvani noted that although there was still an air of sadness about the loss of the cheap fares scheme the Supertram had rekindled interest in public transport.

"There is a sadness about what has happened to public transport in Sheffield in the last ten years, but because of that residual feeling... we have just introduced light rail, it may be a lot of things but one of the things that it is, is an effective public statement. That has not only rekindled interest in public transport, it is sufficiently attractive to attract car users. We are getting car users and 'the business community' [to use the Supertram]." (Interview with Nick Silvani, Transportation Planner, February 1996)

The desire to revitalise the fortunes of public transport in Sheffield was reflected in transport targets set by the Council. As part of a strategy to regenerate the city centre, a target of increasing public transports' share of trips to the centre from 52% in 1991 to 63% by 2006 was set (Sheffield City Council, 1994). The City Council had also focused on reducing the need to travel through land use planning in order to reduce the reliance on the car. In addition to placing considerable emphasis on the role of public transport in the regeneration of the city centre, the Council was also implementing traffic calming programmes in residential streets, starting in the most deprived areas. Public participation has been a central aspect of many of the traffic calming schemes in areas such as Nether Edge, Sharrow, Heeley, Meersbrook, Norton Lees and Tinsley (Sheffield City Council, 1996).

7.6 The influence of Health for All on transport planning

7.6.1 Health for All in Sheffield

The impetus to establish Healthy Sheffield originally came from a combination of concerns raised through reports from Sheffield Health Authority and Sheffield City Council which highlighted issues of health inequalities and ill-health in the city. These concerns were matched by local interest in the World Health Organisation Health for All initiative. Sheffield City Council in collaboration with Sheffield Health Authority, the Chamber of Commerce, Voluntary Action Sheffield, among others, has run a Health for All initiative, Healthy Sheffield (originally called Healthy Sheffield 2000), since 1987. Its stated aims are to help reduce health inequality and improve health.

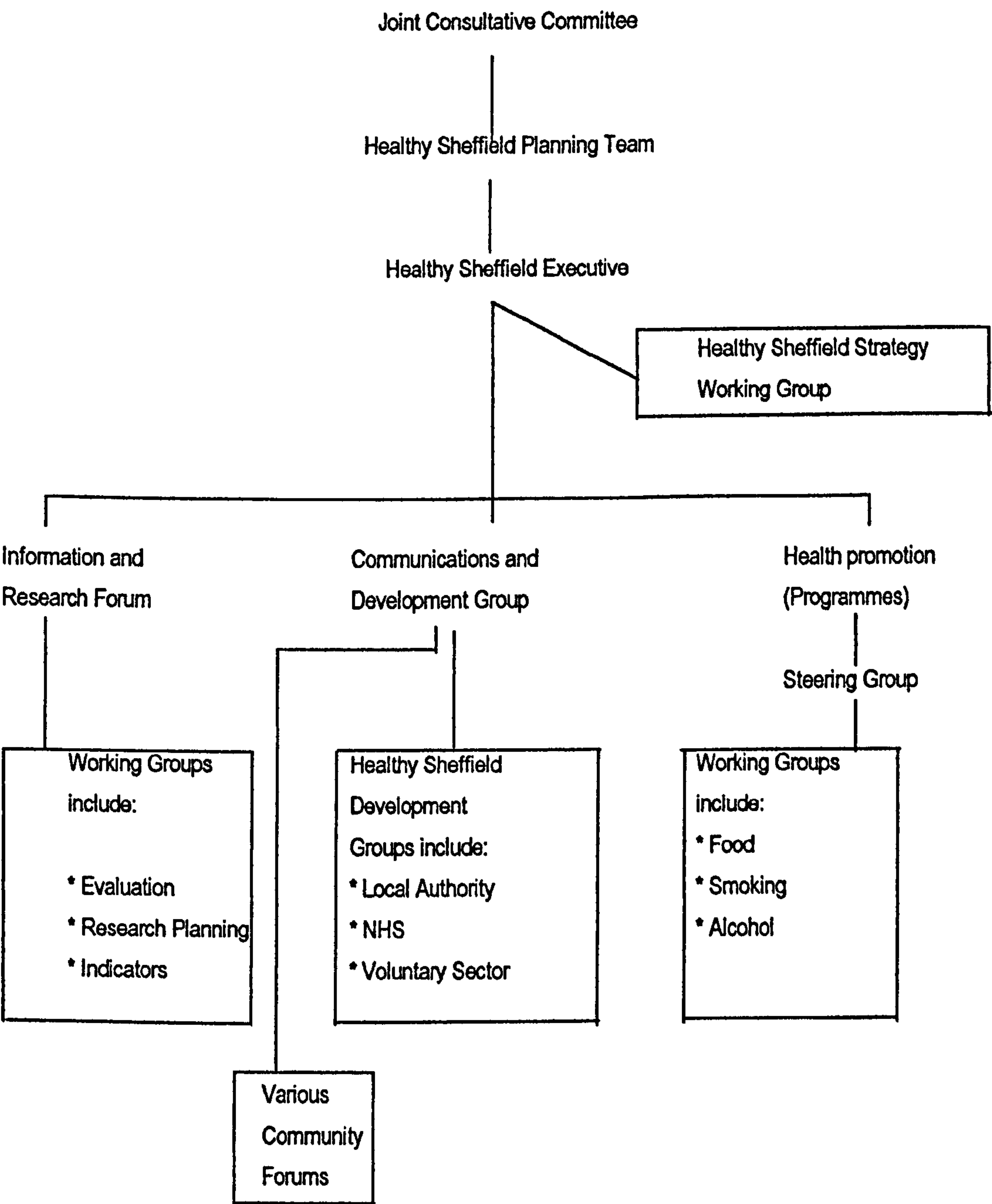
"Healthy Sheffield aims to encourage action across the city which will improve the health of all Sheffield people and significantly reduce health inequality by the year 2000 and beyond." (Healthy Sheffield 2000, 1989a)

It has been claimed that Healthy Sheffield exercises considerable influence on plans for housing, community services, transport and environmental protection and management (Sheffield Health, 1995). The Health Authority and City Council have jointly employed a team of staff, beginning with a Coordinator in July 1988.

Healthy Sheffield is managed by a Planning Team which is a formal committee established under Sheffield's Joint Consultative Committee (Figure 7.4). The Planning Team has representatives from all the partnership organisations (Healthy Sheffield 2000, 1989b). Healthy Sheffield decided to prioritise particular issues like mental and emotional wellbeing, sexual health and accident reduction as part of their early programme of work in the late 1980s. In 1992 Healthy Sheffield produced 'Our City Our Health - Ideas for improving health in Sheffield'. This marked the start of a consultation process in pursuit of the City's first inter-agency health plan. The consultation received over 1500 responses, largely from individuals. From this emerged a Framework for Action document which had three key themes, poverty, discrimination, and the environment.

Political support and endorsement among member organisations of Healthy Sheffield was sought at the highest level for the Framework for Action document. In December 1993 the Chief Executives of the membership organisations agreed a number of priority areas for collaborative effort. These were work, mental and emotional wellbeing, and carers' health (Adams and Cotter, 1995). The City Health Plan 'Our City Our Health - A Framework for Action' was then launched in January 1994, with little reference to the environmental consequences of road transport (Healthy Sheffield, 1994). Environmental issues were consequently not deemed a priority area for the first year after the consultation exercise.

Figure 7.4 Healthy Sheffield Planning Structure



All groups/forums are inter-agency except for the Local Authority Development Group
Structure as of August 1989

Source: Healthy Sheffield 2000, 1989b

7.6.2 Healthy Sheffield and transport planning

Despite the lack of priority for environmental issues in the Health Plan, according to the Assistant Healthy Sheffield Coordinator, there had been a very strong identification with such issues in the public consultation carried out by Sheffield Health. As she noted, the public consultation:

"provided validation for local working on health and environmental issues, particularly environment as one of the major themes touched on by consultation respondents."

(Interview with Valerie Cotter, Assistant Healthy Sheffield Coordinator, February 1996)

The Assistant Healthy Sheffield Coordinator perceived that the lead on transport and health work, which began in 1995, came through the Environmental Health Department, which was seen as being particularly strong on air pollution monitoring.

"Transport came up within that consultation in a number of different contexts. The Healthy City's board decision to prioritise particular issues like mental and emotional wellbeing, and sexual health and accidents were a first wave. Workplace health was within that wave, and carers health. And subsequent to that, within this department, our head of department became very interested in the transport issue from the environmental air quality and the economic regeneration side. He was instrumental in holding a seminar last July at which issues of transport and health were brought up." (Interview with Valerie Cotter, Assistant Healthy Sheffield Coordinator, February 1996)

By late 1995 a Sheffield and Rotherham Transport and Health working group had been set up, initiated by Healthy Sheffield and Rotherham Health for All. The Draft Terms of Reference, as agreed by January 1996, are set out in Figure 7.5. Formal collaboration between the transport planners, the Health Policy Unit and the Health Authority on a transport and health project began by mid 1996. In November 1996 Healthy Sheffield, with Rotherham Health for All, issued a public

consultation document 'Improving Health in Sheffield and Rotherham - the Transport Challenge'. It was a result of discussions with staff in the City Council's Transportation Planning Unit and in the Health Authority, and the other thirteen members of the Sheffield and Rotherham Transport and Health Group.

Figure 7.5 Draft Terms of Reference for the Sheffield and Rotherham Transport and Health Strategy Group

Purpose

To develop an inter-sectoral strategy for transport and health with the aim of raising awareness of transport and health issues in our area and acting as a mechanism for positive change.

Objectives

To increase knowledge on transport and health issues.

To reduce inequalities related to transport use and transportation policies.

To facilitate joint working between Municipal, community, business and academic organisations which have interests in the effects of transportation.

To develop a joint strategy for transport and health with clear recommendations and action plans for positive change.

Guiding principles

The group is guided by the principles of Health for All (at international, national and local levels) and the tenets of sustainable development. The group will work towards a social, environmental and economical vision of sustainable transport.

Health for All and sustainability principles include a belief in the right to health, equity, accountability, empowerment, partnership, community participation and liaison and advocacy.

Membership

The current group membership is:

Sheffield CC - Environmental Protection Unit, Transportation Planning Unit

Rotherham MBC - Environmental Protection Unit, Transportation Policy Unit

Sheffield Health Rotherham Health Healthy Sheffield

Sheffield City Liaison Group Sheffield and Rotherham Chamber of Commerce

South Yorkshire Passenger Transport Executive Friends of the Earth Pedal Pushers

Membership of the group is open to all and other nominees are to be welcomed.

Accountability

Each member of the group will be accountable to their respective organisation through their normal arrangements. Group publications and documents will necessarily represent the views of the whole group.

Frequency of meetings

The group shall meet on a two month cycle or ad hoc if required. Sub groups allotted specific tasks may be asked to meet more frequently.

Chair The group shall elect a chair from its membership to serve for one year.

Improving Health in Sheffield and Rotherham - the Transport Challenge set out a number of health impacts of transport and suggested some ideas for action by individuals, the voluntary sector, business, employers and service providers, transport providers and planning authorities (Sheffield City Council, 1996). The Assistant Healthy Sheffield Coordinator expressed optimism that the Chamber of Trade and Commerce was supportive of drafts of the document from the Sheffield and Rotherham Transport and Health Strategy Group. She noted that:

"A key line coming through [from the Chamber of Trade and Commerce] which sums up for me where we have got to in Sheffield was about changing attitudes to transport so the public transport is a first choice and not a last resort. This strongly stresses working with authority employees and accepts reducing the need to travel, talks about integrated transport systems, and looks largely at how transport in relation to working practices can be refined. But it does say that 'we need to maintain economic prosperity and we don't want to make it difficult for people to access goods and services. We do need to recognise that people do need to travel. What we need to do is to make it happen in a way that is economically prosperous and environmental sustainable in terms of health and wellbeing in the city.' Which I think isn't bad coming from the Chamber of Trade and Commerce."

(Interview with Valerie Cotter, Assistant Healthy Sheffield Coordinator, February 1996)

Improving Health in Sheffield and Rotherham - the Transport Challenge was, however, finalised only after significant disagreements arose, principally between the Chamber of Trade and Commerce and the other organisations. The former had described a draft of the report as 'idealistic' and so would not endorse it, being particularly critical of plans for traffic restraint in Sheffield city centre. The exercise highlighted the fact that different groups had widely differing views about what transport and health were about (McGrogan and Greig, 1997). A key question posed in the document was concerned with improving quality of life and transport's role in this. It noted that:

"the transport debate has broadened to encompass social, economic and environmental implications of present and possible future policies. The question now is 'how can the way in which transport is organised and used in our society contribute to quality of life for all, now and in the future?' (Sheffield City Council, 1996 pp. 2-3)

For Jeremy Wight, the public health Senior Registrar, transport was an issue that he had a long standing personal interest in. In terms of Sheffield Health's contribution to developing policy on this issue, Wight saw his role on behalf of the Health Authority as one of providing support for initiatives on transport and health, and for him to use his influence internally to broaden the Health Authority's perspective. His perspective on the health impacts of transport was broader than that which could be accommodated within a medical model of health. For Wight, these were situated on a spectrum which included those impacts readily quantifiable through to those which were more qualitative.

"I see [health impacts] as going from the hard end of the spectrum, those effects which are very obvious, easily identifiable, easily counted, easily quantified... to a much softer end, the sort of psycho-social aspects of transport problems on health. In that I would include children not learning to come independently to school but being ferried by their parents in car, the stress that is inflicted by current transport patterns both to motorists in traffic jams and to people living alongside busy roads and psychological impacts, the planning blight and loss of communities, all those sorts of things which are soft because they are not easy to define, not easy to quantify." (Interview with Jeremy Wight, February 1996)

Wight became more involved in transport issues during 1995-1996 with the development of work in this area by Healthy Sheffield and the policy initiatives of the City Council, although he was unsure as to the added value of Healthy Sheffield and wondered whether work on transport and

health would have developed anyway. He was viewed by his health authority managers as the 'expert' on transport issues. In the 1996 Annual Report of the Director of Public Health he was able to write that the Health Authority was supporting the Council's bid for funding of a strategic cycle network in the 1996 Transport Policies and Programmes bid to the Department of Transport. Sheffield Health had also drawn up a Transport Policy for itself in order to encourage the use of more sustainable, health promoting forms of transport by staff (Sheffield Health, 1996). However, Wight did note that care had to be taken not to press too strongly on traffic issues as some members of the Health Authority Board were not wholly happy that the Health Authority should be seen addressing this issue.

"There were one or two members of the Health Authority [Board] who were a little uneasy about it and there were one or two suggestions that we shouldn't be banging on so much about transport and private car use." (Interview with Jeremy Wight, February 1996)

Some of the interviewees suggested that Sheffield City Council and the Health Authority were seeking to implement policies on transport and health which were at odds with much of the national policy guidance, and that a framework for collaboration on transport and health was lacking. As noted above, in the transport planning policy arena it seemed clear to the Transportation Planners that there was policy conflict within central government. This was not seen as helping at the local level to achieve policy goals, particularly as the conflict did nothing to reduce the tensions between the Transportation Policy Unit and the Highways Department within Sheffield City Council. This undermined attempts to work effectively intra-sectorally with the City's engineers.

7.6.3 The influence of economic and social regeneration issues on transport and health

An issue raised by all of the interviewees was the regeneration of the city, especially the city centre. From both a health and transport perspective the promotion of the city was a key element

in regeneration programmes. In the late 1980s the city centre had been supplanted as the regional shopping centre by Meadowhall Shopping Centre, four miles north of the city. This, together with the loss of much of the manufacturing base and hence many jobs meant that economic regeneration had become a major theme in Sheffield since the late 1980s (Sheffield City Council, 1994; Sheffield Health, 1995; Loftman and Nevin, 1996).

The concern for economic regeneration had led to some collaborations with the city's two universities and business. In 1992 a City Liaison Group was founded, involving the universities, Health Authority, Chambers of Commerce, and the City Council. The Group developed an action plan for economic development 'Working for Sheffield'. But, according to Cate Jockel, one of the Transportation Planners, there was a general recognition among the City Liaison Group that economic regeneration alone was insufficient. The group therefore set itself the challenge of promoting social and economic regeneration across the city and produced an action plan from this perspective too (Sheffield Health, 1995).

"They realised that the future of Sheffield was not just economic but social development, so they then produced the second report 'Growing together' which, with everybody signed up to this organisation [City Liaison Group], whether they actually agreed the points, but most of the Healthy Sheffield targets and most of the aspirations of Healthy Sheffield have been taken forward in this other document. At least in theory the whole thing is signed up to." (Interview with Cate Jockel, Transportation Planner, February 1996)

The City Liaison Group had recognised that it was important to ensure that all sections of Sheffield's community gained from the benefits of economic growth. The Group, according to its Secretary, John Lambert, was firmly of the view that job creation was central to health. In his contribution to the Director of Public Health's 1995 Annual Report, Lambert discussed the reports on economic and social regeneration and wrote that:

"It is anticipated that next year will see further progress towards the aim of increasing well being through wealth creation, jobs and lessening geographical and social divisions... Success in creating jobs for people would be an important step." (John Lambert, Secretary to the City Liaison Group, in Sheffield Health, 1995 p. 3)

Yet, it was proposals for traffic restraint in the city centre being developed by the Health for All project which, as noted previously, had caused the Chamber of Trade and Commerce to label a draft report as idealistic. This highlights the struggle to find a balance between the health promoting transport identified by Healthy Sheffield and the strong drive among influential groups in Sheffield to place economic regeneration as first priority.

This tension is also highlighted through the experience of Jeremy Wight, the Senior Registrar from Sheffield Health. The issue of economic regeneration created tensions for him within the Health Authority in his attempts to promote some restrictions on car use in central Sheffield and more generally in terms of developing initiatives on transport and health. A Single Regeneration Committee on which the Health Authority, as well as local government authority and businesses were represented, took the view that economic regeneration of the city centre was the priority, to be achieved through investments which provided jobs which, in turn, protected and promoted health. According to the Senior Registrar, the Health Authority Chief Executive took the standpoint, that:

"unemployment is a major public health problem in Sheffield therefore anything that regenerates Sheffield's economy is going to reduce unemployment is going to improve the health of the population. And so while I argue internally within the Health Authority that we should have a more health promoting transport strategy and curb car use and so on and so forth she [Chief Executive] says 'well hang on we can't do that because I am signed up

to all these other things which say 'we have got to regenerate the city centre and therefore you cannot reduce car use in the city centre'. Therefore the messages coming out from this authority aren't always sound." (Interview with Jeremy Wight, Senior Registrar, February 1996)

Wight believed that the priority of economic regeneration meant that more car parking was being made available in the city centre. He saw this as a restriction on his ability to press for health promoting transport policies.

"The big thing that stops us pushing for a healthy transport policy is that there is a very strong perception in the city council that the overriding number one priority for Sheffield has to be its regeneration of the city centre in commercial and business terms... as a result Sheffield City Council's number one priority in the Planning Department is to reinvigorate the city centre and they see, in order to do that, they cannot discourage private car use in the city centre." (Interview with Jeremy Wight, Senior Registrar, February 1996)

As one of the Transportation Planners explained, the detail of the parking policy was not wholly as described by Jeremy Wight. The Health Authority, through membership of the City Liaison Group, may not have been given all the information on the policy, which had been set out in the Councils' main long-term land use policy statement, the Unitary Development Plan.

"What we have said is that we will not cater for any peak hour traffic, and parking provision. However, Jeremy is right in saying that the Council is still saying in terms of viability of retail that we will provide short-stay shopping car parks as long as they don't open before 9.30 in the morning. Even then, what we are talking about is replacement through temporary car parks of what has already be removed. We tackled this through the Unitary Development Plan. We have been much more honest in that than we were through

the City Liaison Group. So yes, that will have health impacts. It is a political balance. Are those impacts going to be better or worse in the city centre? That's an impossible question to answer." (Interview with Cate Jockel, Transportation Planner, February 1996)

This interpretation of policy is confirmed by Council policy documents. The policy was to enable short-stay and restrict long term parking.

"Strong action on all-day parking is particularly necessary in the main urban centres and in central Sheffield most of all. Specifically within Sheffield city centre, new developments are now restricted such that private parking is limited to operational needs only. No further temporary planning consent will be granted for long-stay parking, or any existing consent renewed." (South Yorkshire Councils, 1995 p. 39)

The Health Authority was also concerned that the benefits of economic regeneration be shared across the community in order to counter the polarisation between poor and better off neighbourhoods where economic decline of areas was reinforcing social exclusion (Sheffield Health, 1995). This concern was shared by the Transportation Planners in terms of maintaining the vitality of the city centre as the centre of the public transport network. Nick Silvani, one of the Transportation Planners with Sheffield City Council, saw this as part of a strategy to revive the economic fortunes of the city centre and provide access by public transport for those without cars.

"From a transportation land use point of view we cannot let the city centre shrink because it is the focus of the public transport network [otherwise] the haves and the have-nots will get further apart between those with access to cars." (Interview with Nick Silvani, Transportation Planner, February 1996)

Sheffield City Council's 1994 Transport Package Bid states a target of generating 9,000 new jobs within the centre within a decade. The role of transportation, and public transport in particular, was identified as being crucial. While the Council wished to see more people walk and cycle it believed that

"the major contribution will come from greater use of existing and new forms of public transport." (Sheffield City Council, 1994 p. 6)

Greater use of public transport, walking and cycling could help to reduce air pollution. While air pollution was not particularly poor in Sheffield, according to Valerie Cotter, there was a perceptual problem. Working in the Environmental Services Department, she suggested that there was a concern that Sheffield City Council's investment in air quality monitoring equipment, in 1995, meant that the Council could provide information about air quality which might make people feel that air quality was bad. This might then discourage investment in the city when, in fact, Sheffield's air quality was not as poor as some cities which had not invested in the monitoring equipment.

"We're not bad it's just that we've got good equipment and if you talked about the situation people don't know good or relatively bad it is, and it gives the impression that Sheffield is still a dirty city and it discourages inward investment, whereas there are dirty cities who don't talk about their air quality and therefore people think that it is all right. That's a huge perceptual hurdle." (Interview with Valerie Cotter, Assistant Healthy Sheffield Coordinator, February 1996)

7.6.4 The influence of organisational culture

As noted above, health services in England are located in a separate organisation to local government, the NHS. The NHS has its own organisational culture and ethos. Some of the

interviewees made particular points about the difficulty of working intersectorally between local government and health authorities. One potentially significant barrier to collaboration is that health authorities and local government have different organisational structures and are accountable to different bodies. In Sheffield, while the health authority, Sheffield Health, is accountable to a Board, the local authority's accountability is to the elected members who are voted into office by the adult population. Because of the differences in organisational accountability and the processes for this, such as through reports to elected members in the local authority, collaboration between the two was not always easy to establish and maintain.

The local authority in particular, with its large number of departments provided no one contact point for health promotion work unlike the Public Health Directorate within the Health Authority. The Assistant Healthy Sheffield Coordinator noted that the different structures in terms of accountability within the two organisations affected the speed with which policies were progressed. Sometimes the staff in one organisation didn't seem fully aware of the constraints that those from another organisation were under. So, as Valerie Cotter noted, on occasions there was:

"not a lot of sympathy within either agency to the cultural constraints of the other because even if you work very closely day to day with say a Health Authority and your only contact was dealing with functional problems every now and then, a lot of the local government officers don't have an idea of the autonomy and the expectations sometimes which they do have. There are layers of accountability within local authorities which don't actually exist in the same ways within the health authorities, although I do think that within Sheffield the existence of a Health for All structure helped us to get round a lot of those potential problems." (Interview with Valerie Cotter, February 1996)

From a Health Authority perspective, it was felt that there were different constraints placed on local government to those found in health authorities, particularly the concern of Labour Councillors to remain elected irrespective of the large Labour majority on the Council. Jeremy Wight, the Senior Registrar, thought that the local political decision-making process within local government was important with officers needing to be able to respond to local political issues quickly and adjust policies accordingly.

"There is certainly a very different culture in the Health Authority to the local authority. They obviously have to be much more responsive to local political concerns and particularly leading up to local government elections must suffer a lot of sensitivity from those perceived to be in marginal seats, despite the fact that Labour has a substantial majority. There is increasing concerns about the LibDems getting some seats. Elected Councillors are very sensitive about doing things that might be unpopular and in transport terms that means that they are more reticent about curbing private car use. I think that the authority employees feel hamstrung that they can't push things as far as they would like because of the political considerations. Now we don't have that." (Interview with Jeremy Wight, February 1996)

In contrast, the pressures upon Health Authority staff were in terms of clinical care and waiting lists where there was pressure brought to bear through the NHS hierarchy because of political pressure at national government level. Yet, in the area of environmental health, Jeremy Wight felt that he and his colleagues were less restricted than his local authority counterparts.

"We get the Regional and NHS Executive breathing down on us but in areas of environmental health we don't get this interference that we get in terms of waiting lists. So we have more autonomy in those areas." (Interview with Jeremy Wight, February 1996)

The differences were also partly explained because the Health Authority worked to a different agenda than that pursued by the local government authority departments. Whereas the Health Authority was mandated to work to the national policy as set out in The Health of the Nation White Paper, by contrast, the local authority was working to a range of sectoral agendas through its large number of departments. In some of these departments health had a low profile, exacerbated by the need, first and foremost, to meet minimum statutory service obligations. In addition, the local authority was financially constrained, having been rate-capped in the mid 1980s, and there was general concern that more cuts in jobs might be made. Healthy Sheffield staff working on Health for All issues had to contend with these limitations in one of its key partner organisations.

"Our Health Authority needs to deliver on Health of the Nation and is responsible for working within those constraints. There is a Health for All awareness within the Health Authority. In the local authority there is a Health for All awareness. It is not ubiquitous across the authority and although we have good, strong structures for Health for All and for collaboration for Health for All type projects there is always the danger that the same people, the same enthusiasts get overloaded. And working in a very resource strapped-for-cash type environment it can be hard to push forward a new agenda, which it is, which needs more resources. So that's a constraint." (Interview with Valerie Cotter, Assistant Healthy Sheffield Coordinator, February 1996)

In terms of intersectoral collaboration, the fact that Healthy Sheffield had a multi-agency Health for All structure was seen as ameliorating tensions between staff from different organisations.

"Any sort of Health for All structure does help to provide an arena in which people can become more aware of other peoples' organisations and constraints. It's not just about the relationship between statutory agencies." (Interview with Valerie Cotter, February 1996)

In particular, because the Assistant Healthy Sheffield Coordinator worked for the local authority too, this was seen as helpful by the Transportation Planners for collaborative efforts as she was working within the same organisational structure as them as well as working in a multi-agency structure as part of the Healthy Sheffield organisation. Nick Silvani noted that Valerie Cotter's post as a member of staff of the Environmental Health Department did aid collaboration on transport and health issues even if the process of collaboration was perhaps unstructured to begin with in the early months of 1996. This made collaboration much easier.

"The first time we had contact with Healthy Sheffield was to be asked to give a talk about transportation to one of their meetings. That was from them obviously having internally discussed transportation. And then having made contact 'perhaps we can get together'. But it looks a bit informal and ad hoc. There are no official processes." (Interview with Nick Silvani, Transportation Planner, February 1996)

7.6.5 The influence of professional cultures

The difference in professional cultures between the Health Authority and the local authority staff was viewed as a barrier to intersectoral collaboration. From Jeremy Wight's perspective there were important differences of approach within the Health Authority from that of the local authority. In the former, communication was seen to be better while in the latter, due to the size of the local authority, internal communication and inter-departmental collaboration was seen as being more difficult.

"The difference in culture can lead to misunderstandings sometimes. When I started work [collaborating] with the City Council it took me a while to appreciate that culture. I think that there are some advantages [in the Health Authority] because it does lend itself to better communication because, my perception as an outsider is that, Sheffield City Council is a

very large organisation and some bits of it don't seem to let much light in." (Interview with Jeremy Wight, Senior Registrar, February 1996)

Specifically, Jeremy Wight noted that the engineers and planners were sometimes seemingly unaware of what each other were doing, partly perhaps because of their separate geographical locations.

"The engineers who design and build and the planning department who establish agendas aren't always aware of what each other are doing which might be a result of their geographical separation. I clearly assume that they don't know about work within my remit and make a purposeful attempt to explain... I am sure that they can say the same about us." (Interview with Jeremy Wight, February 1996)

The issue of inter-departmental collaboration was developed by the transportation planners. They noted that the Transportation Planning Unit had been set up originally in 1986 after abolition of the metropolitan authority of South Yorkshire specifically by the Councillors in order to overcome previous tensions between engineers located in a separate department to the transportation planners. Prior to abolition there had been a sense of frustration on the part of the politicians and transport planners who saw themselves as subject to the priorities of engineers working for South Yorkshire Council who were intent on developing road schemes. Post-1986, politicians wanted to change the relationship between the Councillors and ex-South Yorkshire Highways engineers. The Transportation Planning Unit was set up with a very clear political focus, to be responsible for the City Council's transportation policies, with a strong link between the politicians and the officers. For this reason the unit was deliberately created as a mix of traffic and highways engineers and transportation and land-use planners, for multi-disciplinary team working. Indeed, across the Council by early 1996 the politicians had decided that they did not want departments or silos, with professions sectorally isolated. Nick Silvani recalled that:

"Sheffield Members before '86 always saw themselves subject to 'engineers from South Yorkshire telling them what road schemes they were going to have'. And when they took over responsibility in '86 they didn't want the same relationship between Members and officers. They certainly didn't want the same relationship between the Council Members and ex-South Yorkshire Highways engineers. So they [Councillors] set us up with a very clear political focus. The Transportation Planning Unit is responsible for the City Council's transportation policies, all of them, and in close proximity with Members, not just mentally but physically. We sit with the Chair." (Interview with Nick Silvani, February 1996)

For the Transportation Planners this did not overcome difficulties between the Transportation Planning Unit and the Highways division because it led the engineers to see the Transportation Planners as favoured officers by the elected Members. The 1986 structure was:

"good theory if you're a Member, but it creates a lot of friction if you are an officer because you tend to be seen as one of the elite. If we're the 'elite client' absolutely and totally dependent on highway engineers to implement it, there's friction. So we're just at the point of resolving that. We're about to reorganise." (Interview with Nick Silvani, February 1996)

This view about different professional perspectives and the specific problems of working with the highway engineers was reinforced several times by the Transportation Planners. The planners perceived that the engineers were largely concerned with traffic congestion, road accidents, and providing primarily for the free movement of motorists with little thought for the needs of other road users. The Transportation Planners saw this in terms of entrenched views about the role of highways engineers, which the Council leaders wanted to change. For example:

"We have just seen a statement from our colleagues, 'we can't make a cut in this particular area because as a result traffic congestion will increase and there will be more accidents.' There is still a professional feeling there that their jobs [engineers] are to reduce accidents." (Interview with Nick Silvani, February 1996)

The 1996 reorganisation stemmed partly from this particular problem of differing professional perspectives, partly from cutbacks, but also from Council leaders' desire to see more professional behaviour and remove divisive departmental positions.

"Things have been getting polarised. The City Council is going through a lot of cutbacks and there is a lot of defensive behaviour going on, and it's not just in our area. The Leadership has decided that it doesn't want 'silos' and it doesn't want professions, it wants professional behaviour. It is sick to death of the professional ethos." (Interview with Nick Silvani, Transportation Planner, February 1996)

Jeremy Wight, the Senior Registrar from Sheffield Health, thought that a reason why the planners and the engineers did not always work to the same agenda was to do with differing professional goals. This seemed to support the Council leaders' views that 'professions' were making for less effective local government.

"They do seem to have different goals. In the Planning Department, for example, clearly they have different goals from the Transportation people. Design and Build, the engineers, they seem to be able to design and build everything to their own specifications. So there does seem to be a difference in opinion." (Interview with Jeremy Wight, February 1996)

7.7 Drivers of transport planning policy

7.7.1 Environmental influences on transport planning

A key driving force in transport planning in Sheffield in the mid 1990s, according to the Transportation Planners, was to reduce the need to travel, particularly by car by improving the attractiveness of the alternatives, especially public transport. As Nick Silvani commented:

"our overall transportation philosophy at the moment is to reduce the need to travel by land use planning decisions, achieve a much greater proportion of trips by public transport or non-motorised transport, going for a modal split of about 60-40 [%] public transport."

(Interview with Nick Silvani, February 1996)

This is reflected in the 1995/96 Transport Policies and Programmes funding bid to the Department of Transport. This stated that the strategy had three objectives:

- to assist regeneration;
- to influence the way people travel; and
- to influence the location of new developments (Sheffield City Council, 1994).

With regard to health issues, the Transportation Planners' interest had come from their own concerns about environmental issues. Healthy Sheffield had had some influence on their perspectives about health work although it had not instigated it. Rather, Healthy Sheffield was seen as a grouping which might be able to help the Transportation Planning Unit carry forward its own plans. In particular, the Transportation Planners were interested in getting help to develop health messages relating to transport in order to reduce car use, such as through facts about air pollution.

"I think we would say that we have arrived at our transport policies, through our concerns for health, for the environment, just from our own professional point of view. And then found willing collaborators to develop it. Our first approach to environmental health was to say that there is a massive problem in changing peoples' attitudes, can you give us any help in establishing the facts about air pollution? Can you help us set targets and can you help us develop a fairly long term publicity campaign to publicise and promote. That was the first stage and then it was moving on collectively to say that it was not just about air quality, but the next stage was to relate air quality to health so we wouldn't claim that we were 'driving a horse' behind that, there were a lot of concerns." (Interview with Nick Silvani, February 1996)

Augmenting existing support for bus travel with information about the effects of transport on health was seen by the Transportation Planners as a way to improve the public transport share of trips made in the city.

"The difficulty that Sheffield faces getting a modal split to bus is probably not as great as in other cities. There are still more people going to the city centre by public transport than car. There is a problem obviously but we have still got a chance, particularly if we use the health argument to reverse things." (Interview with Nick Silvani, February 1996)

Health was also an issue which the Transportation Planners felt they could address because a corporate objective of the City Council was to create a healthier city. They saw the Transportation Planning Unit as implementing broad Council objectives.

"We work very closely with corporate objectives... [so] Health is right up there, a healthier city..." (Interview with Cate Jockel, Transportation Planner, February 1996)

In Sheffield City Council's 1994/95 Transport Package Bid to the Department of Transport health is discussed in terms of the need to promote it, such as through traffic calming or measures for pedestrians and cyclists. It is also included as part of a Mission Statement in the Package Bid:

"Our strategy requires an integrated approach to different forms of transport within the overall context of the development of the City. Only then can we satisfy the demand for travel in a more fuel and space-efficient way, promote people's health, and protect the environment, and conserve resources." (Sheffield City Council, 1994 p. 1)

7.7.2 Equity as a concern in transportation planning

Part of the drive in transportation planning policy was for a more equitable distribution of benefits from the transport system. As noted above, the Transportation Planners were concerned to ensure that the city centre remained the main focal point in Sheffield, not least because this was the public transport hub. Equity was also a concern regarding the distribution of accidents and pollution for the Transportation Planners. They sought to reduce the threats posed by motor traffic to the most disadvantaged, such as through targeting traffic calming in deprived areas.

"We [Transportation Planning Unit] would rank higher accidents where pedestrians were involved. We have continual arguments about car drivers injuring themselves, driving into trees and we tend to say... politically one of the things we have got to address is that the people who usually have all the advantages are car users and they are damaging the quality of life of others who are already disadvantaged, particularly through health. If you look at the inner city wards where there are health and other social problems, it is those [wards] that are being subjected to the pollution, and they are the lowest [wards in terms of] car owners." (Interview with Nick Silvani, February 1996)

This is strongly reflected in Sheffield's Transport Package Bids in the mid 1990s. These all contextualise Sheffield in terms of the need for economic regeneration and to do so through transport policies which help those with least resources. The 1996/97 South Yorkshire Joint Package Bid had five broad transport objectives, three of which had a strong equity focus to:

- improve transport provision and services to areas of poor accessibility and job creation;
- reduce the demand for travel;
- increase genuine choice of travel mode as alternatives to the private car;
- improve and protect the environment;
- meet the travel needs of the socially and physically disadvantaged (South Yorkshire Councils, 1995).

Despite the fact that Health for All in Sheffield also had a strong equity focus, with its stated aims being to help reduce health inequality and improve health, there was no evidence of a connection being made between equity and transport by Healthy Sheffield in its discussions with the Transportation Planners. The equity concerns raised by the Transportation Planners were not something new in transport, since equity had been a reason for the introduction of the 1975 cheap fares policy.

7.8 References

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Chapter 8

Discussion

8.1 Introduction

The study has focused on the impact of Health for All on transport planning between 1986, when Health for All projects first began to be established, and 1996, by which time all fieldwork had been completed. This chapter addresses the research questions by drawing on the findings from previous chapters. The research questions, identified in earlier chapters, were to assess:

- whether Health for All had any influence on transport planning in the cities under study?
- where Health for All did have some influence, how much and what kind of influence did it have?
- what were the barriers encountered by Health for All in attempts to influence transport planning?
- what evidence was there of intersectoral working and the limits to this?
- what were the most significant drivers of transport planning policy in the cities under study?
- what lessons can be learnt about possible ways forward for Health for All/Healthy Cities in trying to influence transport planning policy?

The following sections directly address these research questions. The fieldwork and archival research have suggested that there were major differences between the three cities in the study but also some key similarities. Section 2 begins by discussing the similarities in the approaches taken by the Dutch and English national governments to Health for All, as well as the rather different approach taken in Denmark. Claims of support for intersectoral health promotion work are compared with the evidence of collaboration. At the city level, the attempts at collaboration on health and transport are also explored and reasons for the different experiences highlighted.

Section 3 considers the barriers to intersectoral work on health and transport. Three key barriers identified were political, professional, and organisational. Some of these barriers involved national as well as local influences on the possibilities for intersectoral work. Other barriers included commonly held interpretations of what the responsibilities of the health and transport sectors were. How these barriers impinged on, and influenced, each Health for All projects' attempts at collaboration on transport are discussed.

Section 4 explores reasons why the City Councils were more or less amenable to collaborative initiatives on health and transport. This involves a discussion of what the key policy drivers were in each city. Three substantive issues were identified in the cities: quality of life, equity concerns, and environment protection. Reasons for the prominence or absence of these issues are explored. The potential links between equity concerns in transport planning and those in Health for All are also highlighted. The implications of the different approaches are compared in terms of whether or not they were conducive to intersectoral collaborations on health and transport.

Section 5 discusses the potential for creating health-promoting transport policy and draws out the key elements required for this, noting these were only found to be present in the Danish case study.

8.2 Main findings: reviewing Health for All policies and influence on transport planning

8.2.1 The framework for Health for All

The Health for All strategy was established by the WHO after the Declaration of Alma-Ata in 1978, and was followed by the development of the thirty-eight targets (WHO, 1985). Health for All provided a framework through which national and local governments could develop initiatives to address the social, and environmental determinants of health as well as the bio-medical. National governments, including the Danish, Dutch and British, signed declarations of their commitment to Health for All in 1985. Some national governments provided initial financial support to the national

networks which developed to service the growing number of towns and cities in Europe establishing Health for All projects from the late 1980s.

The broad range of issues addressed by the Health for All targets (see xiv) included road transport. Target 11 on accidents and Target 21 on air quality can be placed within a medical model of health, concerned as they are with the physical functioning of the body. Other targets also provided opportunities for collaboration on transport, for example, Target 24 on human ecology and settlements. This requires that social and physical environments should be supportive of health. Transport planning plays an important role in influencing social and physical environments.

It was for national governments to choose to develop supportive frameworks in which local Health for All projects could operate. While national government policies towards Health for All were important, it was at the local level that the test of the efficacy of Health for All took place. Action at this level determined whether health projects could have an influence on local policies both within and beyond health services, and affect the conditions and conduct that create health (Milio, 1981). This required political commitment and a willingness across the disparate municipal government departments to enter into dialogue and collaboration on health issues (Costongs and Springett, 1997). Local Health for All projects in all three countries in this study were able to seek advice and support through their national Health for All networks.

8.2.2 National policies on Health for All

Both the Dutch and English national Health Departments made claims for progress on Health for All policies (Department of Health, 1992; Ministry of Welfare, Health and Cultural Affairs, 1993). These claims were largely general rather than specific to policy areas such as transport, couched in terms of emphasising the need for collaboration with other agencies. Despite national government assertions of progress made in the reorienting of health policy towards health

promotion (Wall, 1996), these were largely at odds with the views of policy analysts concerned with Health for All. In both England and the Netherlands, analysts claimed that medical services took precedent over other aspects of Health for All inside the health sector (Dekker, 1994; de Leeuw and Polman, 1995; Delaney, 1996). This focus on medical services made the resourcing of Health for All within health services problematic (Jacobson, 1990).

The prominence of medical services and the treatment of illness is indicative of the continued dominance of the medical model within health care services. This places the role of medical interventions and therapies as central to health. Yet, health care services include health promotion as well. In contrast to the medical model, a social model of health, which underpins Health for All and Healthy Cities, is focused on social, and environmental determinants as well as the bio-medical. It requires much greater attention to be given to health promotion, and the active collaboration of sectors beyond health care services. A social model involves 'upstream thinking', that structural issues, over which individuals may have little control but which can undermine health, are addressed (McKinlay, 1974). This includes poor housing, nutritionally sub-standard diets, and lack of pedestrian and cycle-friendly infrastructure such as area-wide traffic calming and 20 mph zones.

In England, where health care services were not part of local government, the Department of Health identified, in the White Paper, *The Health of the Nation*, the importance of the role of local government in healthy alliances (Department of Health, 1992). The Assistant Healthy City Coordinator in Sheffield claimed, however, that this did not lead to work on Health for All targets focused beyond the health sector because Health for All was seen as part of the health care services' agenda and therefore not taken up by key agencies such as local government. This view finds support in the literature. Moran (1991) noted the rhetoric of Health for All but lack of substance. Rathwell (1992) had highlighted that the White Paper was oriented to the treatment of disease and ill-health through five key areas which related largely to medical targets within Health

for All. Delaney (1996) noted that consequently Health for All achieved only 'soundbite' status in government documents. The Assistant Healthy City Coordinator's claim was also supported by a review of the Health of the Nation policy which noted its health sector focus and consequent lack of ownership beyond that sector (Fulop et al, 1998).

In the Netherlands, the 1989 Collective Prevention Act had been passed by the national government to stimulate health promotion work at the local level. This provided a legal basis for Health for All work. Such legislation might be seen as evidence of the continued devolvement of power to municipal government. This had been a feature of Dutch government policy since the 1970s (VROM, 1997). Evidence from health sector interviewees strongly suggested, however, that despite Ministry claims (Ministry of Welfare, Health and Cultural Affairs, 1993), the Act simply placed responsibility for health promotion on to the municipal government. It did not increase levels of intersectoral collaboration, as the municipal authorities could choose not to undertake health promotion work, if they wished. In addition, national government acceptance of the recommendations of the 1987 Dekker report, a market-oriented review of health care policy, suggests that the Ministry of Health's attention was largely given to overseeing medical services and illness treatment. This is where the financial resources of government were very largely invested. This view was endorsed by Dekker, from the Ministry of Health, who stated that the only clear mandate arising from Health for All to address transport issues was for collaboration on the issue of road accident reduction, and that there had been a standing inter-departmental committee dealing with this issue. It can also be noted that when the National Environmental Policy Plan was jointly published by the Ministry of Housing, Spatial Planning and Environment (VROM, 1989), the Health Ministry was not one of the three other Ministries involved in its drafting. This does not suggest strong inter-sectoral working between the Health Ministry and the Ministries responsible for environment and transport.

In Denmark, support for Health for All was forthcoming as part of general government assistance for health promotion work (City of Copenhagen, 1994). In 1989 the Ministry of Health developed a health promotion programme for the first time in Denmark with eleven other Ministries including Transport. As part of this programme, the 1992 Public Health Insurance Act made health planning for health promotion a mandatory responsibility of the counties and municipalities. This legislation forms part of a continuing process of decentralisation which Danish government reforms had set in train from the 1970s (Ministry of Environment and Energy, 1995). Unlike in England and the Netherlands, no criticism of the national government's policy on health promotion was found either in the interviews or the literature. Health sector interviewees such as Broholm, the National Healthy Cities Coordinator, and Egsgaard, the Copenhagen Healthy City Coordinator, were complimentary about national government support for health promotion work in general. The Public Health Insurance Act was said, by Broholm, to have made the municipalities think more systematically about planning health promotion because they had to develop a plan every four years setting out what they would do. In addition, Egsgaard thought that support for health promotion was inherent in a social democratic country because Scandinavian countries were welfare societies and so gave greater attention to health and social welfare issues than countries such as England. This view was supported in the archival data (Swedish National Board of Health, 1993).

Evidence of specific collaborations on health and transport at the national level in all three countries were limited to those issues where there had been a medically accepted causal link between ill-health and transport. This was restricted to traffic casualties (as noted by Dekker in the Netherlands), and sometimes also to the effects of air and noise pollution. It is notable, however, that pollution matters were principally the responsibility of environment rather than transport departments in all three countries. This meant that traffic casualties was the only substantive link between the health and transport departments within the national governments. Such collaborations had existed prior to the establishment of Health for All, and national

government policies on health and transport had not been influenced by Health for All. Other impacts of transport on health were largely ignored, giving support to the claim made about health policy in England, that transport is a hidden issue (Jones, 1994).

Within national policy documents there was little evidence of collaboration between health and transport ministries encouraging alternatives to car use and which addressed Health for All targets beyond medical services. Some evidence for this is found in England, although only by the end of the study period, with the launch of a *Strategy Statement on Physical Activity* (Department of Health, 1996). This Strategy made reference to Department of Transport work and the role of transport in physical activity promotion. A specific link was with the National Cycling Strategy, launched by the Department of Transport in the same year. No evidence was found in the health and transport policy literatures for similar links in either Denmark or the Netherlands. Strong environmental policies had, however, been developed since the 1970s in these two countries and environmental concerns were interwoven into the national transport policies. The importance of environmental issues will be addressed in section 8.4.

8.2.3 Health for All at the city level and levels of influence on transport planning

At the city level, intersectoral collaboration initiated by Health for All projects had some limited influence on transport departments. At best, health issues were taken up by transport departments as an additional justification for further actions in pursuit of stated transport policy goals. This was the case in both Copenhagen and Sheffield. While health issues provided justification for action there was no evidence to show that health issues changed the general emphasis of transport planning policy.

In Copenhagen, where evidence of collaboration was greatest, the Healthy City Project was able to work with the Roads Department. The Roads Department was responsible for the implementation of a motor traffic reduction policy (City of Copenhagen, 1991). It had already

overseen a decline in motorised traffic in the city from the 1980s and a significant reduction in traffic accidents. Specifically, the reduction in traffic accidents was a prerequisite for the development of intersectoral collaboration on health and transport. As several Danish interviewees noted, the decline in accidents provided the City Roads Department with the confidence for a broader approach to health and transport. Through a Health Profile, the Healthy City Project was able to provide a new perspective on the impact of transport on health and quality of life (Healthy City Project, 1992). The Healthy City Plan, which the Healthy City Project was required to undertake by the WHO, provided a mechanism through which the Roads Department could develop further its existing policies to promote alternatives to car use. This was exemplified by the chapter on transport in the Healthy City Plan which set targets for changes in travel behaviour towards physically active transport (Copenhagen City Council, 1994).

With political commitment to health promotion and the Health City Project by Copenhagen City Council (Healthy City Project, 1994), there was a formal structure for collaboration through the Project, and the resources necessary to support collaborative working. This included funds for the city-wide Health Profile and the production of the Healthy City Plan. Political commitment, supportive structures, and sufficient resourcing, are elements identified as important if collaboration is to be effective (eg Hanf and O'Toole, 1992; Curtice, 1993; London Research Centre, 1993; Delaney, 1994a). The requirement to produce a Healthy City Plan gave Copenhagen some advantage over Groningen and Sheffield. As traffic issues were important in political discussions in Copenhagen a programme proposing actions on transport to improve health had to be included when drafting of the Healthy City Plan began in 1992. In Groningen and Sheffield, Healthy City Plans were not required as part of a condition for the continuation of the Health for All projects. There was also less evidence of political support for action by these Health for All projects to address traffic issues.

Another important element in effective collaboration for Health for All work was the development of good working relationships, and a shared sense of purpose and trust among staff with mandated authority. Such a working relationship was operating between the Copenhagen Healthy City Coordinator, Egsgaard, and the Roads Department transport planner, Eir. The importance of a shared sense of purpose was stressed by Hudson (1995), that of trust by Webb (1991), and mandated authority by the London Research Centre (1993). In developing collaborative work on transport and health, Egsgaard and Eir played key roles in a bilateral relationship. Egsgaard, the Healthy City Coordinator, was an experienced administrator, responsible for the Health Profile which was produced by the Health City Project to raise health as an issue within the various City Council departments. This was necessary because, as he stated, other departments did not generate ideas themselves for promoting health through their work. The Health Profile was successful in drawing Eir's attention to the possibility of applying health to facilitate transport policy development.

The concept of reticulism proved a useful one here since it drew our attention towards people who possessed skills in bilateral communication, and negotiations (Power, 1973; Friend, Power and Yewlett, 1974). The fieldwork highlighted that reticulists existed and were important in facilitating effective inter-sectoral and intra-sectoral collaboration (Hudson, 1995). In Copenhagen, Egsgaard acted as a reticulist, progressing policy by bilateral collaboration with Eir. Egsgaard's background as a hospital administrator, together with the experience he had gained since the Healthy City Project was established in 1988, enabled him to judge well the contacts and processes most likely to be productive in developing intersectoral collaboration on transport issues. By collaborating with Eir, Egsgaard had established a working relationship with someone at the appropriate level in the Roads Department in terms of authority and ability to develop and carry forward transport policy initiatives.

For his part, Eir, by his own admission, was not a typical traffic engineer. He thought it important to say that he was different from the typical engineer. The transport literature review portrayed engineers as people trained to view quantitative data as legitimate data and are suspicious of 'soft' subjective data (Sharp, 1973; Hall, Hebbert, and Lusser, 1993). Having worked for some years in transport planning, Eir felt that he had a broader view of issues than most engineers, which allowed him to work in a less constrained way, such as by giving weight to qualitative as well as quantitative data as generated through the Health Profile. Eir was personally supportive of measures to promote positive health and quality of life rather than simply seeking to limit the negative effects of motorised transport.

In Groningen, the Health for All Project also attempted to interest other Council departments in collaboration by bringing new research to their attention. Bazuin, the Health for All Coordinator, described this as a 'coming-in gesture'. This involved efforts to demonstrate that health issues were relevant to specific departments by tailoring research to what Bazuin thought would generate interest within a particular department. In comparison with Copenhagen, the process of developing intersectoral collaboration was substantially undermined, however, by the lack of political support within the transport department for collaboration with the Health for All Project. In Groningen, unlike in the other two cities, there was no evidence of collaboration between the Health for All Project and officials working on road transport issues. This meant that Health for All had no discernible influence on transport planning in the city, and this was reflected in the lack of reference to Health for All in transport policy documents (for example, Groningen City Council, 1992, 1993). Unlike either the Healthy City Project in Copenhagen or Healthy Sheffield, the Groningen Health for All Project was not well resourced, with just one part-time member of staff. This limited the ability of the Co-ordinator to invest time in developing mutual understanding and to exchange and share beliefs and values with staff from other sectors, such as transport. The importance of investing time in developing mutual understanding was stressed by Grey (1985), and the exchanging and sharing of beliefs and values by Costongs and Springett (1997).

Transport issues figured little in the work undertaken by Healthy Sheffield until 1995. In 1995, when such work began, the choice of issue was air pollution. This exemplified the type of collaborative links being made between the health and road transport sectors in England up to this time, both at the national and local level (Davis, 1995: Green, 1995). It also meant that Healthy Sheffield continued to focus on the burden of disease and ill health resulting from motorised road transport and limited Health for All transport work to Target 21 on air pollution. This happened in spite of criticism by the Assistant Healthy Sheffield Coordinator of national health policy as being 'limited in scope, and medically orientated in terms of health.'

The focus on air pollution by Healthy Sheffield was highly compatible with the work of the Environmental Health Department where Healthy Sheffield was located, since the Department was responsible for monitoring air quality. Concerns about air pollution voiced by Healthy Sheffield arose partly because Sheffield City Council had, in 1995, invested in air pollution monitoring equipment. This technology provided publicly available data as to air quality in the city. As the Assistant Healthy Sheffield Coordinator stated, public perceptions of poor air quality in Sheffield could act as a disincentive to investment in the city despite the fact that the air quality was no worse than in any other city. This could be a sensitive issue for a City Council and a health authority focused on job creation and revitalisation of the city centre. Focusing on air quality would be important in allaying potential business investors' concerns by showing that the City Council was taking positive action.

8.3 Barriers encountered by Health for All in attempts to influence transport planning

A range of barriers to inter-sectoral work was identified through the fieldwork. Three main categories emerged through the data, and had different degrees of influence in each of the cities. These barriers were: political; professional; and organisational.

8.3.1 Political barriers

Cosijn, the Dutch national Health for All Coordinator identified that political commitment was central to the success of Health for All and Healthy Cities, as did the WHO (WHO, 1994). This was absent in Groningen. The Health for All Coordinator, Bazuin, complained that politicians in the transport department were not interested in Health for All but focused on other agendas. A number of other findings also suggest that there was less than full commitment from Groningen City Council's politicians and senior officials. Firstly, the passing of the Collective Prevention Act, which was designed to give municipal authorities responsibility for health promotion, did not lead to greater inter-sectoral collaboration, but rather, as Bazuin stated, confirmed the pre-existing situation in terms of work on health promotion. The Act had little, if any, influence in Groningen. Goumans, the University researcher, and Dekker, from the Ministry of Health, both commented that while local Health Service Department officials raised health promotion issues within municipal government meetings, officials from other departments generally did not.

Secondly, and similarly, the incorporation of Health for All at a national level into the Assembly of Dutch Towns in 1994 implied political support for Health for All. Yet, it had no discernible influence in Groningen Health for All Project's attempts to collaborate with the transport planners. Dekker highlighted how many Alderman (Mayors) tended to equate health with hospitals and medical services, creating political barriers to Health for All initiatives beyond health services. This suggests that health was conceived of by politicians, and non-health sector officials alike, as the responsibility of health services departments, but not also of other departments.

Thirdly, the appointment of a part-time officer, almost inevitably meant that progress on Health for All work in Groningen would be slow, indicating limited political support within the Health Services Department, as well as across the Council more generally. It suggests that health promotion was not a priority for the City Council. This is reflected in the health policy literature review, that competition for political favour and conflicting priorities within departments in climates of scarce

resources could be a barrier to intersectoral collaboration for health (Delaney, 1994b). These findings challenge the claim made by the Ministry of Welfare, Health and Cultural Affairs (1993) that intersectoral policy was being progressed as a result of the Collective Prevention Act, at least in so far as transport planning was concerned.

Compared with the Health for All Project in Groningen, in Sheffield, Healthy Sheffield was relatively well resourced, and there were claims that it was quite effective in influencing City Council policies (Sheffield Health, 1995). Yet, the evidence from the interviews suggested that efforts to address health and transport issues were subservient to the overriding goal of economic regeneration. Firstly, the concerns of potential business investors in Sheffield were considered by the City Council, the Health Authority, and other members of the City Liaison Group, to be more important to address than the concerns of Sheffield residents. The residents' concerns had been identified through the 1992 Healthy Sheffield public consultation. It was believed, however, by the City Liaison Group that Economic regeneration of the city would deliver jobs through which health would best be promoted. This approach contrasted with that of Copenhagen where the focus was on addressing residents concerns about air pollution and too much traffic. Secondly, a consultation document produced by the Sheffield and Rotherham Transport and Health Working Group in the middle of 1996, did discuss a range of transport related health issues but highlighted disagreements between the Chamber of Trade and Commerce and other members of the Strategy Group during drafting of the document (McGrogan and Grieg, 1997). This was despite optimism expressed by the Assistant Healthy Sheffield Coordinator as to an emerging consensus about the draft document in February 1996. Such tensions between economic development and health promotion initiatives have been highlighted in the literature (Baum, 1993). Thirdly, environmental issues were not seen as sufficiently important for Healthy Sheffield to address them until 1995. This was despite public concerns about the environment having been identified in 1992 through Healthy Sheffield's public consultation in 1992.

In Copenhagen, political rivalries in the City Council could block collaborative working between officers. The Danish government system, while being less oriented to one party domination, did allow Mayors of differing political persuasions to hold office, heading city departments. This then created political tensions when the Lord Mayor blocked initiatives because of the opposing politics of one of the departmental Mayors. Yet, as a result of support for the Healthy City Project and the City Council policies for motor traffic reduction political barriers to collaboration on health and transport were minimised. Efforts could be directed both to reducing the negative effects of motor traffic and promoting health enhancing travel modes.

8.3.2 Professional barriers

A critical issue identified in this study has been the understanding of what is meant by the term 'health', particularly among professions beyond the health sector. In the Netherlands it was stated by the National Health for All Coordinator, Cosijn, that promoting Health for All initiatives amongst traffic engineers and environment staff was difficult as they found it hard to make links between the policy areas. In Groningen, the transport planner's lack of inclusion of the Health Services Department in his list of collaborators suggests that he perceived health to be concerned solely with medical services and illness treatment.

The perception of health as illness among non-health sector professionals, and therefore the responsibility of health services departments, was specifically identified by three of the interviewees, Goumans, Dekker, and Egsgaard. It was also identified in the literature that there exists a pervasive myth that good health is the result of medical and hospital services (Goldstein, 1997). This was in spite of evidence to the contrary (McKeown, 1976), and practical efforts to dispel the myth such as through awareness raising training in local government (Pike, O'Keefe, and Pike, 1990). This perception presented a professional and cultural barrier to Health for All. It reduced the likelihood of health work beyond the health sector within the three countries,

irrespective of the differences in culture which might themselves influence the way health was conceptualised.

Optimistically, Cosijn thought that policy areas traditionally associated with health such as social services and education were less problematic to work with because the professions involved accepted the links between health and their areas of work. The literature on this issue, at least in the UK is less optimistic. Experiences of collaboration between health and social services suggest that issues such as cost-containment, differing professional cultures, and mistrust arise, even in areas with established links. These present considerable barriers to collaboration (Hudson, 1987, 1995; Hiscock and Pearson, 1999).

This highlights the issue of professional boundaries, what Degeling (1995) termed 'sectoring'. Specialised discourses of knowledge and expertise help professions to maintain legitimacy, making understanding of their work difficult to those outside. Sectoring can be applied to all professions, so that while the term health is strongly linked to the dominance of medicine in the health sector (Degeling, 1995), the transport sector can also seem impenetrable to non-transport professions. Goumans felt that transport issues did not have a very high profile in Health for All work in the Netherlands. They appeared low on lists of priorities and then when cited, discussed in terms of pollution and accidents, issues which were viewed as technical. This suggests that transport was also perceived in a narrow and quantitative way by Dutch Health for All professionals, reflecting the dominance of technical and quantitative approaches to transport issues cited in the literature (Sharp, 1973; Healey, 1977). For example, it is notable that reference to collaboration between the Dutch Health Ministry and the Ministry of Transport in the 1992 Netherlands health policy document *A strategy for health* addressed efforts on transport at reducing road accidents (Ministry of Welfare, Health and Cultural Affairs, 1992). This again gives support to the view voiced in the literature that transport is, for the most part, a hidden health issue (Jones, 1994).

In Copenhagen, by way of contrast, the transport planner, Eir, did not find the perspectives of public health doctors and environmental health officers particularly helpful. He saw their concerns to quantify health impacts, as focused on illness rather than positive health. Their reliance on quantitative approaches consequently made discussions with such professionals problematic for Eir. Rather, Eir's positive interpretation of health was akin to those in the literature on healthy cities who have argued that a positive focus on health rather than disease should be central to Healthy City projects (Kelly et al, 1993).

8.3.3 Organisational barriers

One question to emerge early in the research was whether organisational structure had a significant influence on inter-sectoral collaboration. Specifically, this question arose because of the existence of the National Health Service in England which is separate to local government. The organisational structures in Denmark and the Netherlands contain health services within municipal government. In theory, inter-sectoral collaboration would be more difficult in England because of the differences in organisational cultures between local government and the National Health Service. Fragmentation of responsibility, and lack of guidance on joint planning, have been identified as barriers (Moran, 1991). There was evidence that this was the case in Sheffield, not least because of the wide range of City Council departments, with different policies and political agendas, budgets, and professions, operating across the City Council.

Healthy Sheffield did, however, provide a forum for discussions, acting as an inter-sectoral link between its funders, Sheffield Health and the City Council, and other agencies in the city. Both the Assistant Healthy Sheffield Coordinator, Cotter, and Silvani, a transportation planner, reported that its existence did make collaboration easier. Nonetheless, Healthy Sheffield was unable to compensate for some of the organisational barriers generated by the separation of health services from local government. Nor had Healthy Sheffield managed to generate much

dialogue between itself, the City Council transportation planners, and the Health Authority, since its establishment in 1987 up to 1996 as was epitomised by the lack of attention given to transport issues in the City Health Plan (Healthy Sheffield, 1994).

While Danish interviewees did report difficulties in working inter-sectorally, the explanations offered differed to those identified in Sheffield. Having spent most of his working life with Copenhagen City Council, Eir thought that working for the same organisation which employed health and medical staff did not necessarily make collaborations with such professions easier. Departments were focused on their specific areas of work, which precluded a broader view of policy. More importantly, Eir noted that cross-departmental discussions with colleagues were not that difficult but that the politics of the Mayors could act as a barrier to collaborations. Mayors of opposing political views were less willing to work collaboratively, as Skaarup, the Environmental Health Officer, had also described. Egsgaard cautiously suggested that collaboration should be easier because of the unitary system where health services were part of municipal government, and Rindel, the Epidemiologist, felt that the structure made it slightly easier than in England.

Seeking to assess differences in barriers resulting from differing organisational structures is problematic unless an individual has experienced working in similar roles in both systems. It is, therefore, unlikely that interviewees can give much more than a feel for whether the system they work in is better or worse than another. Nonetheless, the simple separation of health sector work from local government does raise an additional potential barrier to inter-sectoral collaboration given that there will inevitably be different organisational cultures operating. Evidence from the health policy literature supports the view that collaboration between organisations is harder to forge and maintain than within them (Webb, 1991). Even between policy areas with mutual interests, such as health and social services, there can be significant barriers (Hudson, 1987; Hiscock and Pearson, 1999).

8.4 City level policy drivers

The findings from this study provide support for previous claims that health in itself does not have intrinsic value for policy makers at the city level. Therefore, it is important for Health for All projects to ascertain what are the key policy drivers at the local level and work through these so that health concerns inform other areas of public policy. Health then needs to be translated into values related to those policies (de Leeuw, 1998) to avoid being perceived as predominantly the responsibility of health service departments. In the following section, key themes identified as transport policy drivers in the three cities are discussed in order to highlight those themes Health for All projects may find most valuable when seeking to collaborate with transport professionals.

8.4.1 Quality of life

Quality of life was found to be a transport policy driver within two of the cities, to varying degrees. The level of prominence given to quality of life was dependent upon political support for issues and concerns not captured by quantitative data. It was most prominent in Groningen where a central goal of City Council policy was improving quality of life (Groningen City Council, 1992; 1995). Here, it was a means by which health concerns arising from road transport could be accommodated in the City Council's transport policy irrespective of the lack of collaboration between the Health for All Project and transport planners. This was illustrated by van der Klaauw's examples of the importance for people of having access to travel in order to be involved in the daily life of the city. Quality of life concerns were also reflected in Council policy statements about giving priority to public transport and the use of bicycles and the need to provide for car use in a selective way (Groningen City Council, 1992).

While improving quality of life was not a stated policy goal in Copenhagen, it was an important issue to emerge through the Health Profile, which was focused on perceptions about health (Healthy City Project, 1992). Egsgaard, the Healthy City Coordinator, was able to talk of 'health in the sense of quality of life', while Eir, the transport planner, spoke of how quality of life concerns

were included in political discussions about what actions might be taken to reduce the negative effects of motor traffic. As in Groningen, therefore, quality of life concerns were 'fed' into political considerations and so influenced policy. In contrast, discussions about quality of life were least prominent in Sheffield, being raised once by the transportation planners in the context of equity concerns, and appearing in a statement on transport and health in 1996. It was otherwise absent from concerns articulated by interviewees or archival sources.

In both Groningen and Copenhagen, quality of life was conceptualised as encompassing a broad range of issues relating to daily life, not just physical and mental functioning. It was with this environmental account of quality of life in mind that Goumans, who had studied Health for All in the Netherlands and the UK, felt that quality of life might be a better label than health in order to avoid the appropriation of health as illness and so engage policy sectors beyond health. An environmental 'label' rather than Health for All or Healthy Cities would still mean focusing on the same type of work. The literature was able to provide environmental accounts of quality of life which reflected everyday experiences of people in which health is just one factor that is important to them (Grayson and Young, 1994). In contrast, most of the health accounts found in the literature were oriented to medical services and the treatment of illness within health care services and the physical functioning of the body (Ruta and Garratt, 1994).

8.4.2 Equity

There is a marked similarity between the emphasis upon equity in Groningen City Council's approach to transport and the approach to equity found within Sheffield's transport policies. Like Groningen, where a Socialist group introduced the traffic circulation plan in 1977 to provide a better environment for pedestrians, cyclists and public transport users, a socialist-led Sheffield City Council had introduced a cheap fares policy from the 1970s through to the mid 1980s. An equitable distribution of the costs and benefits of transport continued to be a concern of the Sheffield transportation planners during the mid 1990s, evidenced through the funding bids to the

Department of Transport (Sheffield City Council, 1994; South Yorkshire Councils, 1995). In Groningen, as part of the Council's approach to quality of life, it had sought to promote and protect the most vulnerable groups and make access around the city easier for them. As van der Klaauw stated, people had to have freedom from dependence on others and be able to maintain social networks irrespective of whether they had an income in order to promote their quality of life. In both Groningen and Sheffield there was recognition that the selective distribution of access results in diminishing opportunities for vulnerable groups, such as the elderly, children (Hillman, 1993), and the poor being excluded from valued activities (Sheffield City Council, 1987; Grieco, 1989).

While policies in Sheffield changed from the late 1980s due to the need for economic regeneration, the City Council remained committed to equitable public services. As part of the programme for economic regeneration, action plans for economic and social development were produced by the City Liaison Group. A similar approach was developed in Groningen. Both van der Klaauw, and Bazuin, the Health for All Coordinator, spoke of the need for social cohesion and inclusion, and identified the publication, by the City Council, of Physical and Social Structure Plans to address these issues.

While concerns for equity in transport were voiced by interviewees in Sheffield and Groningen, and also identified in official reports (Sheffield City Council, 1996; Groningen, 1992), such concerns were not drawn upon by the Health for All projects as a means by which to develop intersectoral collaboration and action. This was a missed opportunity in both cases given the strong focus on equity in Health for All. It suggests a lack of understanding by those Health for All projects of the drivers of transport policy in their respective cities. In Copenhagen, equity issues were largely absent from discussions about health and transport, although the National Healthy Cities Network Coordinator did remark that there were concerns about equity in Denmark. One reason may have been, as Egsgaard stated, that Denmark was a social democracy, with equity

considerations substantively built into the structure of Danish social welfare provision. Consequently, this may have lessened the need for a focus on equity in health and transport work, and contrast with the more overt concerns for equity found in Groningen and Sheffield, cities in liberal democracies.

8.4.3 Environmental protection

Environmental protection policies, that is, the application of a range of measures to reduce car use and consequently pollution, were prominent in Copenhagen and Groningen. In Copenhagen, a policy of motor traffic reduction was the key driver of the City Council's transport policy (City of Copenhagen, 1991). Transport planning to control private motor transport had a long history in Copenhagen, with the Fingers Plan being developed in the late 1940s to steer development along public transport corridors (Ministry of Environment and Energy, 1995). Similarly, a key policy underpinning Groningen's transport planning was the idea of the compact city, keeping distances short (Second Chamber of the States-General, 1992). This had been critical in enabling large numbers of people to cycle in order to access jobs and services. Implemented for environmental reasons, these policies, nonetheless, had important health benefits for many citizens as a result of reduced car use. These benefits included low pollution levels, a physically active population, and equitable access to jobs and services.

In Copenhagen, the relatively low level of car use and the decline in traffic casualties were prerequisites for effective collaboration on health and transport, rather than reasons for not addressing transport issues. They gave the Roads Department confidence to look beyond its traditional remit and to consider health and quality of life issues. There was also political support for this approach because the politicians wished to address the decline in the city population resulting from public concerns about too much traffic and air pollution. This highlights the fact that despite the evidence from quantitative data which could show that Copenhagen had relatively low levels of pollution, car use and traffic casualties compared with other cities, public perceptions

were influenced by daily experiences which led to different interpretations. People perceived their health and quality of life to be unsatisfactory partly because, as Skaarup the Environmental Health officer suggested, they travel outside the city and so compare their experiences.

In Sheffield, the aspiration of the transportation planners was for environmentally-led policies, notably through reducing the need to travel by car. This was not, however, a key policy driver for Sheffield City Council and environmental policies took second place to the over-riding concern of the City Council for economic regeneration of the city. This was especially so in the city centre which had been weakened with the opening of the Meadowhall shopping complex on the edge of the city, as well as through job losses in manufacturing. Creating 9,000 new jobs in the city centre was a goal of the City Liaison Group which represented major employers in Sheffield, including the City Council and the Health Authority (Sheffield City Council, 1994). This marked Sheffield out as having a distinctly different main policy driver compared with either Copenhagen or Groningen. In contrast to Sheffield, neither of the continental cities were in economically weak positions. Copenhagen, as the capital city of Denmark, was the national centre of Danish commerce, while Groningen was a regional centre, with few other towns or cities close enough to compete for jobs. This suggests that in less prosperous cities it may be hard for Health for All initiatives to gain political support for transport work when issues such as unemployment are high on the political agenda. This does not imply, however, that Health for All work in relatively prosperous can easily develop transport initiatives, as the case of Groningen demonstrates, where for different reasons political support may also be low.

Nonetheless, there were similarities in policy approaches between Sheffield and Groningen. Both sought to establish a balance between what were seen as conflicting needs, for economic development, and environmentally protective transport policies. In Sheffield, economic regeneration was clearly the priority, although accessibility needs were planned around increasing use of the public transport system as well as car use. In Groningen, with less need for

attention to economic regeneration, the focus was firmly on restricting access to the city centre in order to protect quality of life, particularly for pedestrians (who may also be public transport users), and cyclists. In contrast, in Copenhagen, economic development was viewed to be in accord with the transport policy of reducing motor traffic in the city. Politicians believed that revenue would be lost to the City Council if they were not supportive of measures to address public concerns about the effects of too much traffic (Healthy City Project, 1992), as some residents would leave the city.

8.5 Lessons for Health for All in influencing transport policy

The findings from the fieldwork and archival research suggest that Health for All work on transport in the Netherlands and England was largely focused on those of the 38 targets which were oriented towards the treatment of disease and ill-health. As a result, accidents and pollution were seen as the mutually accepted areas for collaboration between health and transport professionals for nearly all of the period between 1986 and 1996. This finding is supported by the health and transport policy literature which suggested only limited collaborations between these sectors. One reason for this limited collaboration is that the word 'health' carried with it connotations of hospitals, medical services and the treatment of ill-health. Consequently, this was a barrier to progressing Health for All targets relating to transport beyond those defined by a medical model of health.

Where transport policies were environmentally-led and there was political support for Health for All work, both at the national and local level, health concerns could provide support for further development of health enhancing transport policies rather than initiatives which only sought to ameliorate the more widely recognised negative impacts of transport on health. These prerequisites were only found to be present in the Danish case study. They are illustrated in Table 8.1.

Table 8.1 Factors contributing to health promoting transport planning through Health for All initiatives

	Netherlands	Denmark	England
Support for Health for All at the national level	Low	High	Low
Support for Health for All at the local level	Low	High	Medium
Support for environment-led Transport policies	High	High	Low
Likely influence of HFA on transport at the local level	Low	High	Low

The pre-conditions for intersectoral collaboration on health and transport found in the thesis, therefore, comprised a number of elements. Firstly, that Health for All initiatives focused on intersectoral collaboration needed to be well resourced and with political commitment from local and national politicians. This occurred only where an official WHO Healthy City had been established, in Copenhagen. A second pre-condition was that transport planning needed to be environment-led both nationally and locally, providing a supportive policy environment, and that traffic restraint should be a policy goal. In addition, the thesis found that transport planning professionals were more open to Health for All initiatives where the transport sector had been successful in reducing traffic casualties while supporting modes of transport other than the car. However, Health for All collaboration was fruitful only in Copenhagen where the Healthy City Project was able to identify issues such as quality of life concerns which had resonance with the transport planners and local politicians.

Another finding of the study has been that, irrespective of the influence of Health for All, environmentally-led transport policies implemented at the city level in the Netherlands and Denmark delivered significant health benefits as a result of the relatively favourable levels of cycling and low levels of car use. This is compared with the higher levels of car use found in Sheffield, where environmental issues were given less prominence in transport policies. A reason for this is that the Dutch and Danish national governments began to address environmental issues from the early 1970s and to incorporate them into other policy areas, such as transport, from the mid 1970s. As a result, the implementation of traffic restraint policies in cities such as Copenhagen and Groningen provided significant protection and a supportive environment for alternative modes of travel to the car. This occurred some twenty years before policy began to change more favourably towards environment-led transport in England from the mid 1990s. During this period car use had continued to grow while use of alternatives continued to decline so making change away from car oriented policy more difficult to achieve. Ironically, the socialist City Council of Sheffield had instigated a low fares policy for public transport which had slowed car ownership growth in the city compared with the rest of the country and provided accessible and affordable transport for much of the city's population. This ended with bus de-regulation, stemming from the Conservative government's 1985 Transport Act. (Sheffield City Council, 1987; Goodwin, 1990).

In Groningen, environmental concerns were incorporated into quality of life considerations, whereby issues such as motor traffic were accepted as having significant impacts on the life of the citizens. As a result, traffic restraint measures were viewed as making an important contribution by providing a balance between the need for economic prosperity and environmental protection. This finding was supported by evidence in the health policy Chapter, with some quality of life accounts embracing a broad range of issues beyond physical and mental functioning.

The findings from Groningen on the effectiveness of Health for All with regard to transport highlight the need for political commitment to Health for All at both the national and local levels. Without this it is difficult to have sufficient levels of resourcing, including officer time, in order that dialogue can be established and a shared sense of purpose and trust developed between sectors with no previous contact. It is notable that although the Healthy City Project in Copenhagen played a key role in stimulating transport policy initiatives, a prerequisite for the Project's existence was the City Council's willingness to enter into a contract with the WHO. This then provided resources and a structure for intersectoral collaboration, reflected in Project outputs such as the Healthy City Plan.

The experience of Sheffield City Council highlights the importance of equity concerns as a policy driver. The implementation of a public transport cheap fares policies in the early 1970s, arising from an equity-driven transport policy, had afforded the population of Sheffield with some important social health benefits for over a decade: greater access; stronger social networks, and low transport costs (Nicholl, Freeman, and Williams, 1987). Many of these benefits were lost when the policy ended in 1986. Concerns about equity were clearly still present in the approach pursued by Sheffield City Council transportation planners in 1996. Yet, economic regeneration of the city meant that health issues only began to receive some attention when air quality became a possible barrier to business investment.

As noted above, equity was not drawn upon either by Healthy Sheffield or the Groningen Health for All Project as a means by which to provide a common agenda between health and transport. This is despite the fact that equity is one of the six major themes running through Health for All policy. This was a missed opportunity for the Health for All projects in both cities.

Lastly, health concerns were not notable features of transport policies in two of the three cities. This is a finding supported in the health policy literature that, in itself, health does not have

intrinsic value for policy makers at the city level. The difficulty for Health for All projects is that transport policy, like any other policy area, has its own set of policy drivers and imperatives. It is, therefore, important for Health for All projects to be able to translate health into values with resonance in transport departments, such as those centred around issues of equity, environment, or quality of life.

8.6 References

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Chapter 9

Conclusions

9.1 Introduction

The primary objective of this thesis has been to explore the influence of Health for All on transport planning policy between 1986 and 1996. In particular, the thesis has sought to:

- compare English, Dutch and Danish approaches to intersectoral collaboration on transport and health using specific case study examples and examine the role of Health for All in each case
- assess the influence of Health for All on transport planning policies in each case
- highlight those case examples of intersectoral collaboration on transport and health where transport policies were influenced by Health for All, and the policies, practices and other methods used
- identify the potential for health promoting transport planning in England.

In order to achieve these goals the thesis has reviewed a broad range of literature on transport planning policy, the theoretical underpinning for, and development of, Health for All project work, and definitions and debates about intersectoral collaboration. The thesis has identified the impact of Health for All on transport planning in Denmark, the Netherlands and England between 1986 and 1996. It has explored attempts at intersectoral collaboration on health and transport by drawing on archival data and key informants in the health and transport sectors in Denmark, the Netherlands and England. In particular, this has been realised through case studies which have addressed efforts to develop intersectoral collaboration on health and transport in the cities of Copenhagen, Groningen and Sheffield. Through this approach the research has confronted barriers to, and potential for, intersectoral collaboration. In general, key informant interviews confirmed the types of barriers and opportunities identified in the literature.

9.2 Methodology

In Chapter 4 I set out the methodological approach, which was to use a combination of archival and interview data. This was in order to combine, compare and contrast national and municipal government accounts with those of practitioners in exploring the influence of Health for All on transport planning. A pilot case study confirmed that such an approach could generate rich data. The archival data provided both national and local government perspectives, and set out claims for progress in the implementation of Health for All. It was possible, however, to gain only limited information from health sector documents which specifically referred to transport. This itself suggests the paucity of attention to transport issues within health sector work.

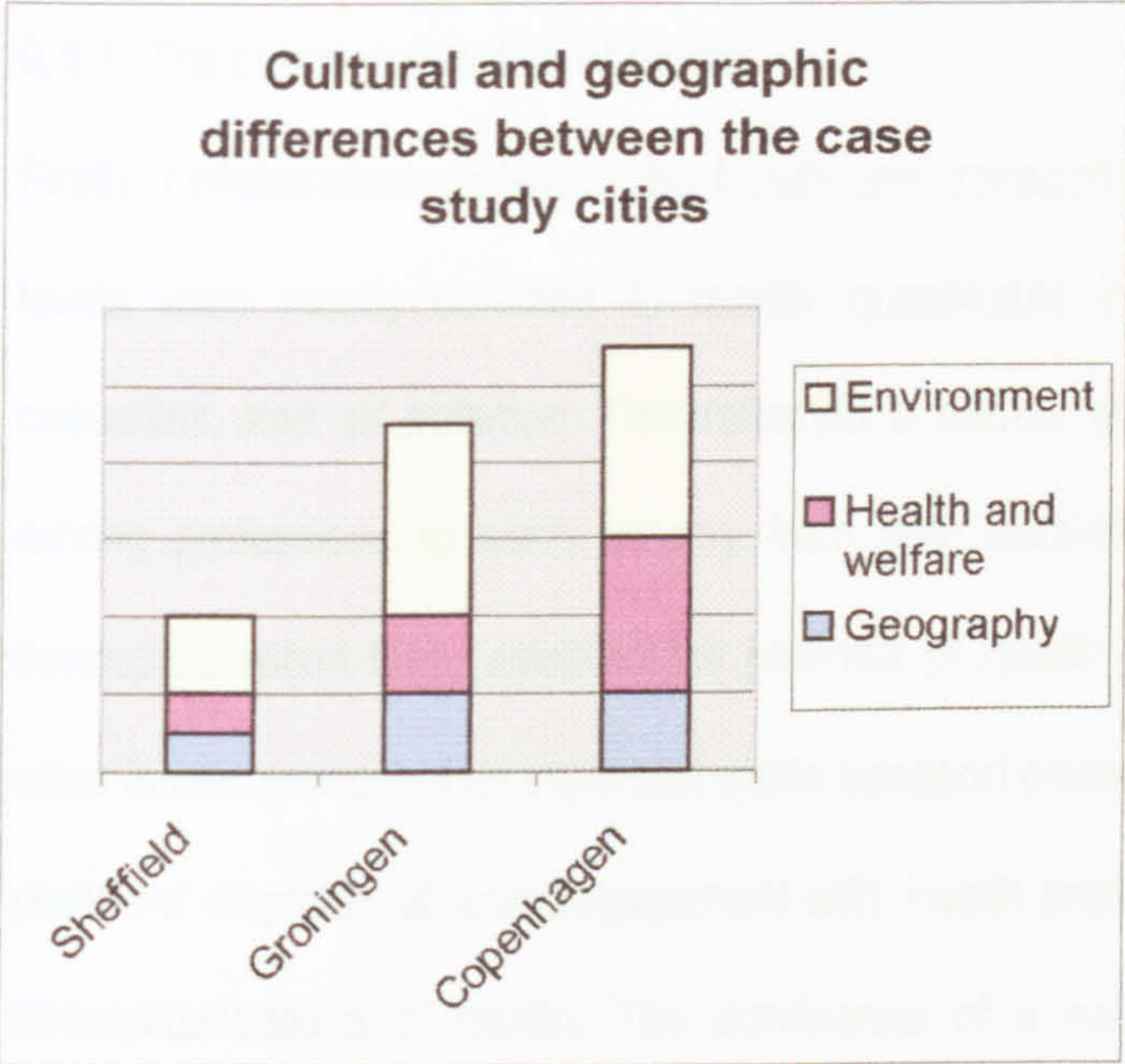
The study has taken into account the strengths and weaknesses of qualitative research, and the need to address the weaknesses through rigour in design, data collection, and analysis. It has identified key informants in each country and city, identified largely through use of the snowballing technique, conducted semi-structured style interviews, and sought to let issues and concepts emerge through the generation of the data. This method provided flexibility in the conduct of the interviews and gave interviewees opportunities to raise issues important to them while ensuring that key issues, such as those identified during the pilot study, were also addressed.

In interpreting the data generated, the approach of drawing out key themes through the grouping of archival and interview data was an important way in which to identify what themes were noted to be important, and by whom. This also enabled the data to be examined a number of times in order not to miss key points. The six key themes identified provided the basis for the development of the fieldwork chapters, having first been grouped by country. Returning to the interview tapes so as to remind myself of the interviews again provided a means of self-checking, whether particular issues might have greater or lesser importance than I had previously given them, or new issues revealed through a further hearing.

In addition to this process of grouping themes and reflection on the data, triangulation played an important role in giving confidence to the findings by counteracting the threat to validity in each set of data. Triangulation helped in analysis to confirm or challenge accounts. For example, national government statements gathered through archival data claiming progress for Health for All work sometimes conflicted with a consensus among key informants working at the city level that this was not so.

Transferability of the findings is important, not least when undertaking an international comparative study. Some significant historical, cultural and geographical differences between the countries were evident, with an important outcome being differences in approach to both health and transport policy in each country. The Dutch population density is slightly higher than for England and considerable more so than compared to Denmark, with the consequence that pressures on land use as a limited resource are high. Concerns about the impact of industrial activity on the environment were voiced with effect from the early 1970s in both Denmark and the Netherlands with respective national governments taking actions to address pollution issues. In this regard, England lagged behind some twenty years. Table 9.1 illustrates the importance of cultural and geographical factors indicative of their contribution to health and transport collaborative action, in each of the three case study cities.

Table 9.1 Cultural and geographical factors indicative of their contribution to health and transport collaborative action



The Danish and Dutch national governments' tangible support for environmentally-led transport planning is transferable to an English setting if there is political will to internalise and give priority to environmental protection issues in transport policy and planning. A barrier to this, however, is that there remains in England a politically powerful roads lobby, which in part, reflects the significant role of motor vehicle manufacturing in the economy. In addition, in the case study city of Sheffield the focus on economic regeneration, and in consequence a lesser standing for health promotion concerns, raises the issue that it may only be in relatively wealthy cities where basic needs such as low unemployment and low road traffic casualty levels have been achieved that health promoting transport policies can be considered. Moreover, the Danish approach to health promotion may be more problematic and may be less transferable because of the character of the Danish welfare state. There are also other barriers, as discussed above, which may inhibit political support both for health promotion work on transport at the national and local level.

9.3 Main themes

Four main themes can be identified as arising from this research.

9.3.1 The conceptualisation of health

Firstly, collaborations between the health and transport sectors at both the national and local levels were mostly confined to readily quantifiable impacts of transport on health: traffic casualties, and air pollution. This reflected a narrow conceptualisation of health as ill health among professions in each country from both outside and within the health sectors. This conceptualisation then restricted the potential of Health for All projects to identify and address other issues perceived as important within transport planning at the local level because transport planners' cognition of, and engagement with, health professions was often constrained by their conceptualisations of health. The dominance of a narrow conceptualisation of health also highlights the relative weakness of Health for All within health policy (Delaney, 1994), marginalised by health care focused on treatment of the sick (Jacobson, 1990; Nutbeam and Wise, 1996).

While barriers to Health for All work such as the conceptualisation of health as illness, and sectoral interests, has been voiced in the literature (eg Hudson, 1990; de Leeuw, 1998) there was no body of literature which had previously addressed barriers to intersectoral collaboration on health and transport. This thesis has shown that such barriers do operate at the inter-face between health and transport. The thesis also identified no evidence of proposals for concepts of health which may have intrinsic value for transport policy makers at the local level. This is perhaps not surprising given the paucity of research into intersectoral collaboration on health and road transport.

9.3.2 Influence of national policies

Secondly, the influence of national policies on transport and health promotion is critical to the potential influence of Health for All on transport planning at the local level. The thesis has identified the importance of Health for All projects at the local-level working within supportive national health policy frameworks. National governments must not only make statements of endorsement for Health for All but also provide tangible support across the range of public policy concerns reflected in the 38 Health for All targets. This requires a commitment to a model of health which encompasses social and ecological determinants rather than one which is solely located in a medical model of health. The implication of this is that the broad spectrum of public policy incorporates health concerns, as encapsulated by the concept of healthy public policy, discussed in Chapter 3. Therefore, Health for All at a national level must be developed through the active involvement of all relevant Ministries, not just Health.

Similarly, the research suggests that it is important that national transport policies are environmentally-led. This then provides a framework within which local-level transport planning can focus on reducing the negative impacts of private motor traffic *and* positively promote travel by more environmentally benign modes. If such a transport policy framework is in place, health promotion work, such as through Health for All projects, can more readily identify health and transport policy goals which are mutually supportive and develop intersectoral action.

The thesis has found that only where health care policy provided tangible support for health promotion and national transport policies were environment-led were there the necessary resources and political commitment at the local level for Health for All work which sought to promote health through transport planning. A reason for this was that in Denmark, health promotion was relatively new, with the Ministry of Health establishing its first programme in 1989 with eleven other Ministries, including Transport. The Ministry of Health acknowledged that the programme was adapted from the WHO Health for All strategy (Ministry of Health, 2000). In turn,

this gave encouragement to municipal authorities interested in Health for All and specifically to Copenhagen in becoming a WHO-designated Healthy City. In the Netherlands and England, health promotion was not so new, having evolved through health education, as discussed in Chapter 3. National health care policy in these countries was more firmly grounded in caring for the sick, with criticisms from among interviewees, and in the literature concerning a lack of support for Health for All, especially those of the 38 targets focused beyond disease and ill health (Dekker and Saan, 1990; Rathwell, 1992; de Leeuw and Polman, 1995; Delaney, 1996). Nonetheless, it is important to note that where transport policies were environmentally-led, they could facilitate health promoting transport and so contribute to Health for All targets irrespective of health policies. In this regard the thesis indicates that England lags behind both Denmark and the Netherlands in seeking to develop a national framework for transport which is environmentally-led. Environmental issues only began to be addressed in transport policy and planning in England from the 1990s in contrast to the 1970s in Denmark and the Netherlands. This suggests that environment-led transport policy is a pre-requisite for health promoting transport, a foundation from which health promotion initiatives can help to develop such policies through stressing the relevance of health promotion to transport planning policies.

The underlying reasons for the slow pace of development towards environmentally-led transport planning in England were, as Chapter 2 identified, strongly related to the path of industrialisation taken in England. The manufacturing base in England was developed earlier than in either Denmark or the Netherlands because of the primary position of England in the industrial revolution. Moreover, in the twentieth century after the Second World War the English economy was re-built with motor manufacturing playing a significant role, unlike in either Denmark or the Netherlands. English transport planning also drew on North American models which were heavily car-oriented so that mobility concerns became dominant over those of access which could have been largely met through environmentally-led transport planning. In this the role of the highway engineer in re-shaping the environment was prominent, and this dove-tailed with the idea of

progress, that mechanisation, including by greater car use, equated with progress and advancement of a society. This was underpinned by the support of successive post-war UK Governments for road building and linked to a stated policy goal of universal car ownership, absent in both Denmark and the Netherlands.

This is not to ignore the fact that the car and motor traffic growth were significant issues in both Denmark and the Netherlands. The challenge of rising car ownership in countries was, however, met with differing approaches to that taken in England. It is notable that there were no equivalents to the Buchanan Report of 1963 ('Traffic in Towns') in either country nor the political impetus for road building found in England. In Copenhagen the introduction of the Fingers Plan, in 1949, to control development was partly a response to observations of land use and transport in the United States. The Fingers Plan was implemented in order to keep developments focused along key public transport served corridors. In both Denmark and the Netherlands debates about the environment and pollution from the 1960s provided a back-drop for transport-specific concerns. In the Netherlands with pressures on land use density higher than elsewhere in Europe, redevelopment plans for parts of towns and cities in which new roads were proposed, including in Groningen, resulted in local opposition which overturned the plans and led to traffic restraint schemes as part of alternative programmes.

In essence, in England an engineering culture in transport planning reflected the prominence of engineering in the development of English commerce from the industrial revolution. In contrast, Denmark and the Netherlands, countries without significant motor manufacturing bases, were countries without effective roads lobbies. They were also countries where ties with the physical environment have been arguably stronger than in England during the second half of the twentieth century. In Denmark the prominence of the agrarian economy well into the twentieth century, and in the Netherlands with the continued need to protect low lying land from the threat of flooding,

have been factors which have made policy changes to environment-led transport planning less problematic.

9.3.3 Disciplinary boundaries

Thirdly, the narrow specialist fields developed within public policy administration, as typified by municipal government departments, and the separation of the NHS and local government in England, made intersectoral action between disparate disciplines difficult. Pressure to manage core functions, and to protect sectoral budgets from 'cost-shunting' and other perceivably negative intrusions, meant that the task for Health for All projects of engaging with disciplines such as transport planning was problematic. Limited evidence of previous collaborations between the health and transport sectors suggests that the task may be particularly difficult. The literature, however, offers little evidence that collaborations between health and other policy areas even with some inter-linking concerns, such as social welfare, are unproblematic (O'Neil et al, 1997; Hiscock and Pearson, 1999). To some degree narrow disciplinary approaches engender ignorance of the functions of other professions (Nocon, 1989), as was found in Groningen where the transport planner knew little about the City Council's Health for All project. In addition, effective collaboration is only possible where there is a shared sense of purpose (Hudson, 1995) and trust (Webb, 1991). Professional disciplinary and sectoral barriers were also linked with political barriers. Where politicians conceived of health as concerned with medical services this then supported and reinforced professional disciplinary boundaries, not least because officials carry out policy set by politicians.

9.3.4 Finding common ground between Health for All and transport planning

The thesis has identified three concepts which provide common ground between Health for All and transport planning: quality of life; equity; and environmental protection. Both quality of life and equity were identified within the Health for All targets but not utilised by the Groningen and Sheffield Health for All projects which had no or little success in developing intersectoral action

on transport. There was evidence that concerns for environmental quality provided a basis for intersectoral collaboration although this was largely focused on air pollution information rather than transport planning policy change. Quality of life was also a central objective of Groningen City Council's policies, and interpreted by the department responsible for transport planning as giving priority to modes of travel other than private motor transport.

A review of the quality of life literature identified that an environmental account of quality of life can address peoples' physical and psychological experiences of life, and that this can be inclusive of concerns for health. In this way an environmental account can capture public attitudes, including the understanding of how health is influenced through the everyday experiences of the outcomes of transport policies. It was an environmental account of quality of life, generated through a Health Profile of residents in Copenhagen, which signalled to local politicians that there was a need to take further action to reduce motor traffic in the city. This then provided the link between health promotion and transport developed in the Healthy City Plan.

9.4 The implications for health policy

What are the implications of the research for health policy and specifically for Health for All? Firstly, it is important to highlight that, between 1986 and 1996, road transport as an area of health policy research was largely ignored in all three countries. This then provided no or little stimulation for discussion about how health policy, and in particular, how Health for All could begin to address the many and varied impacts of transport on health and work with transport planning professionals. This thesis has illustrated significant drivers of transport policy and hence where the most fruitful opportunities for intersectoral collaboration and action may lie for Health for All projects. It is important, too, that the relationship between health and transport planning should be studied because transport contributes significantly to the environmental and social determinants of health, and forecasts for road traffic growth suggest that transport's contribution to these determinants will also grow.

I have highlighted claims that work towards the implementation of Health for All was hindered by a 'business as usual' ethos within health care services in most European countries. Together with evidence that national governments in the Netherlands and England spoke the rhetoric of Health for All but that it gained only 'soundbite' status, the continuance of such an approach may afford little opportunities for Health for All projects to address issues beyond traffic casualties and pollution. The overwhelming focus in health care of the treatment of the sick means that Health for All cannot be achieved without radical changes in society (Farrant, 1991; Baum and Saunders, 1995). There appears to be greater potential for change, and so the attainment of Health for All goals and targets beyond the treatment of disease, through pro-active health promoting policies in sectors other than health. The transport policies of Groningen and Copenhagen provide evidence in support of this conclusion.

Traffic casualties and pollution have been, and remain, important issues within transport planning. They only address, however, the most readily quantifiable negative impacts of road transport on health. For example, as Chapter 2 identified, the trend of overweight and obesity is, in part, an outcome of increasing car dependence. This is a European-wide phenomena and one which the increasing motorisation of these countries has contributed to. The 1996 Strategy Statement on Physical Activity published by the English Department of Health could be seen as an initial step in providing opportunities for intersectoral collaboration between the health and transport sectors focused on health promotion (Department of Health, 1996). Since this time in England there have been further Department of Health initiatives to promote physically active transport. If these could be translated at the local level, through collaboration between health promoters and transport planning professionals, more people might feel able to walk and cycle as part of their daily travel needs. As Chapter 5 demonstrated, the Copenhagen Healthy City project was able to develop intersectoral action on transport which involved a programme to help facilitate further physical activity through active travel.

While this thesis has highlighted concepts such as quality of life and equity, which could provide links for Health for All projects with transport planning, it would be more fruitful to the achievement of Health for All goals if the transport planning sector were to pro-actively seek to work with health promoters. Since transport policy makers can significantly influence the health impacts of transport they need to be able, therefore, to identify the advantages of intersectoral collaboration with health promoters. This suggests that Health for All advocates need to invest resources in highlighting how transport goals and objectives can be assisted through intersectoral collaboration with health promoters. There is also a rationale for this from a transport perspective. As more European municipal authorities seek to control the impacts of road traffic in their localities, health becomes a valuable additional justification when developing the case for traffic restraint measures. Therefore, transport planning could utilise health concerns more effectively in support of environmentally-led transport policies, as Sheffield's transportation planners were seeking to do.

9.5 Recommendations for further research

This thesis can only be regarded as an account of intersectoral collaboration on health and transport undertaken during the period between 1986 and 1996. Knowledge and interest in health and transport has risen significantly since 1996, reflected in the choice of transport as a key topic by the WHO for the 3rd Ministerial Conference on Environment and Health, held in London in June 1999. Since the mid 1990s, the amount of interest in intersectoral collaboration on health and transport in England has grown and the potential for collaboration was significantly enhanced by increasing attention on the value of physical activity as part of daily travel, given that many journeys are under two miles in length (Health Education Authority, 1999).

During the course of the research a number of areas were identified as ripe for further exploration. One of these is further work to explore the means by which health issues can be

translated into values with resonance in transport departments since this was a serious weakness for Health for All in two of the three case studies. Another and related area identified where further research could prove valuable is a study of the concepts of health held by politicians and transport planners. This would help in better understanding their underlying assumptions and hence where they feel the political responsibility for health lies, and what, if any role they believe they should play in health promotion. This could assist in further identifying issues and values which have resonance with transport policy makers and hence where health promoters may find success in attempts at intersectoral collaboration.

Particular questions raised through this research but which were beyond the scope of study include:

- the relative importance of social welfare within the structure of nation states as a determinant of the influence of health promotion policies;
- whether health promotion legislation stipulating specific outputs (such as four year plans) makes intersectoral collaboration and action on transport more likely than where no such legislation has been enacted;
- whether WHO designated Healthy Cities projects are more effective than Health for All projects in developing intersectoral action on health and transport, and if so, whether or not this is because of the required political commitment from municipal governments by the WHO?

Finally, there is a need for studies which explore issues around intersectoral collaboration and transport across the range of European countries actively involved with Health for All. A larger pool of data on attempts at intersectoral collaboration on health and transport in Europe could help to map out how varying approaches to public policies at both the national and the local level influence such collaborations, and illustrate more comprehensively the types of initiatives which may best serve to promote health for all.

9.6 An update on English transport and health initiatives 1997-2001

At the close of Chapter 2 I provided a review of transport and health collaborations in England up to and including 1996. Since that time there have been a number of policy developments. Not the least of these was the Integrated Transport White Paper, 'A New Deal for Transport: Better for everyone' (Department of the Environment, Transport and the Regions, 1998), published in the wake of the Labour Party election victory. This made a number of statements relating to health and transport, including the need for measures to support walking and cycling. Key to the document was the idea of integrated transport and helping people to have available to them the use of alternatives to the car. As such, access became a cornerstone of transport policy and the need to ensure that this was better for everyone. Subsequent guidance to highway authorities from the then Department of the Environment, Transport and the Regions did highlight the need for collaboration with health sector professionals at the local level in the development and implementation of policy.

Following the Integrated Transport White Paper, the Health Education Authority published several reports on aspects of transport and health although the subsequent demise of the Health Education Authority and its replacement by the Health Development Agency in April 2000 has resulted in a loss of impetus from what was the lead health agency in promoting the links between health and transport.

Another impetus for the promotion of health and transport collaboration was the third Environment and Health Conference, coordinated by the WHO Europe, and held in London in June 1999. In the planning for the event a group of European researchers were funded to draft papers to provide the scientific basis on which more health conscious transport policy was to be developed. The Conference was attended by many of Europe's Environment and Health Ministers who signed a Charter on transport, the environment and health. The Charter seeks to

promote strategies and plans of action by Member States of the WHO Europe to promote transport systems which are sustainable for health and the environment. Its contents are likely to be reflected in a further revision of the European Health for All targets.

One particular health concern, which has highlighted the need for more opportunities for people to be physically active, is the trend of overweight and obesity. While diet is an accepted aspect of these conditions it is generally accepted that the most significant 'lifestyle' contributor is that people are taking less physical activity as the need for physical activity has been increasingly replaced by machines. A National Audit Office report, of February 2001, estimated the cost to the economy from obesity, and identified the importance of transport in helping people to increase energy expenditure, control body weight, and reduce the risks of ill health associated with obesity (National Audit Office, 2001). Given the clear trend towards overweight and obesity, increasing concerns over body weight may provide one clear link to physical activity as part of meeting travel needs. This is predicated, however, on commitment from both central and local government to infrastructure measures which make walking and cycling the easy choices.

By the late autumn of 2001, looking back over the past four years, the outcome of such initiatives has been to raise the profile of the value of health and transport collaborations. While there is evidence of more intersectoral collaborations in order to promote health, there is also more rhetoric than action. This may be explained in part, at least, by the fact that health promotion concerns have partly been assimilated, and overshadowed, by concerns to reduce social exclusion. This appears to be a major policy focus of Central Government. Indeed, in 2001 the Social Exclusion Unit, set up by the Prime Minister's Office shortly after the Labour Party came to power, turned its attention to transport issues, issued a consultation paper, and contracted some transport academics to advise on progress.

Whether social inclusion remains the most favoured policy concept in the next few years is questionable. Yet, whatever the favoured policy steer, wheresoever the policy environment for health promotion within transport planning is potentially favourable, advocates of transport planning for health will need to be able to translate health into values with resonance in transport departments.

9.7 References

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APPENDICES

Appendix 1

Interview checklist

1. Introduce myself, reminder as to my field of research, mentioning other interviewees being interviewed in the country/city, set up tape recorder and test.
2. Ask the interviewee to say something about their role within the organisation they work for, and their own background (training).
3. a (for non Health for All interviewees) Whether their work involves them in collaborating with people in other policy sectors. If so, with whom?
b. (for Health for All interviewees) How they approach intersectoral collaboration and progress to date, especially with regards to transport planning.
4. How the structures of Government affect intersectoral collaboration.
5. The influence of politicians on their work.
6. Their perspective on the health impacts of road transport.
7. Ask about specific policy goals (eg local and national transport policy objectives) and how they influence collaboration on health and transport.
8. Their involvement in specific city-based initiatives.
9. Their perspective as to the importance of the local Health for All project in influencing transport planning.

Appendix 2

Interviewees and their designation

Netherlands

Hermien Bazuin, Health for All Coordinator, Public Health Services Department, Groningen City Council

Janine Cosijn, National Health for All Coordinator, Public Health Services Department, Eindhoven City Council

Dr. Evert Dekker, Policy Development (Healthy Cities), Ministry of Welfare, Health and Cultural Affairs

Marleen Goumans, Department of Health Ethics and Philosophy, University of Limburg, Maastricht

Cor van der Klaauw, Transport Planning Officer, Department of Town Planning, Traffic, Transport, and Economic Affairs, Groningen City Council

Denmark

Kit Broholm, Healthy Cities Network Co-ordinator, National Board of Health

Jens Egsgaard, Healthy City Co-ordinator, Health Services Department, City of Copenhagen

Bjarne Eir, Planning and Analysis Office, Roads Department, City of Copenhagen

Dr. Anne Rindel, Epidemiologist, Medical Office of Health, City of Copenhagen

Raymond Skaarup, Air Quality Division, Environment Agency, City of Copenhagen

England

Valerie Cotter, Health Policy Co-ordinator, Environmental Health Department, Sheffield City Council, and Assistant Healthy Sheffield Co-ordinator, Healthy Sheffield (based at Environmental Health Department)

Cate Jockel, Planning Officer, Planning and Economic Development Department, Sheffield City Council

Nick Silvani, Senior Planner, Transportation Unit, Planning and Economic Development Department, Sheffield City Council

Dr. Jeremy Wight, Senior Registrar, Public Health Department, Sheffield Health (the health authority)